NATIONAL UNION OF HEALTHCARE WORKERS

866-968-NUHW • nuhw.org • info@nuhw.org

December 20, 2024

Mary Watanabe, Director
Dan Southard, Chief Deputy Director
Sarah Ream, General Counsel
Sonia Fernandes, Deputy Director, Office of Enforcement
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Dear Ms. Watanabe, Mr. Southard, Ms. Ream and Ms. Fernandes:

On behalf of the National Union of Healthcare Workers (NUHW), I am submitting a complaint regarding Kaiser Foundation Health Plan's widespread services reduction for enrollees with substance use (SUD) and co-occurring disorders in Southern California.

I. Summary

Since October 21, 2024, Kaiser has drastically reduced services for its Southern California enrollees with SUD and co-occurring disorders. These reductions include, but are not limited to, the following:

- Failure to provide timely and appropriate Individual treatment
- Reduction in group treatment for mild-to-moderate SUDs
- Reduction in group treatment for severe SUDs
- Imposition of Kaiser's illegal "One-Appointment-at-a-Time" rule
- Understaffing of SUD treatment
- Use of untrained and inexperienced SUD staff
- Failure to perform assessments and treatment planning

Kaiser's practices constitute violations of multiple California laws, as detailed below. Patients who do not receive timely and appropriate SUD care are more likely to experience relapses and other harms, including death. NUHW has confirmed relapses among Kaiser's Southern California enrollee since October 21, 2024.

Additionally, Kaiser continues to impose an illegal non-quantitative treatment limitation (NQTL) on Southern California enrollees' SUD and mental health care. Details regarding Kaiser's "one-appointment-at-a-time" rule are contained in this complaint. NUHW first reported these violations in a formal complaint to DMHC dated November 2, 2018. Subsequently, NUHW filed additional complaints with DMHC regarding this

practice on October 21, 2019 and June 17, 2021. The October 11, 2023 DMHC-Kaiser settlement agreement finally cited Kaiser for this practice as a violation of the Mental Health Parity and Addiction Equity Act.[1] Nonetheless, DMHC has failed to require Kaiser to cease its violations. Consequently, today – more than six years after NUHW first reported Kaiser's violations to DMHC – the violations continue unabated, depriving enrollees of their right to appropriate care.

II. Evidence

During the past week, NUHW interviewed staff and gathered documentary evidence from six of Kaiser's 13 Southern California services areas regarding Kaiser's addiction medicine services. The following summarizes NUHW's findings regarding Kaiser's practices since October 21, 2024:

Failure to Provide Timely and Appropriate Individual Treatment: Following October 21, 2024, some of Kaiser's addiction medicine clinics stopped providing individual appointments to enrollees in active treatment. This cessation of care occurred due to Kaiser's failure to transfer striking therapists' caseloads to temporary replacement staff. For example, on October 21, 2024, three teen enrollees were undergoing active treatment for SUDs in the South Bay service area. In the preceding weeks, they had received diagnostic intake assessments, been diagnosed with SUDs, and began teen Intensive Outpatient Programs (IOPs) while also receiving individual psychotherapy at Kaiser. When the strike began, Kaiser failed to transition them and all of the other patients in the therapist's caseload.[2] Consequently, the three teens did not receive any individual psychotherapy for their SUDs for more than a month, although such care was part of their treatment plans. Similar failures affected the patients in other therapists' caseloads. According to staff, Kaiser inconsistently transitioned enrollees to temporary services due to a lack of planning, coordination and quality oversight.

Reductions in Group Treatment for Mild-to-Moderate SUDs: Since October 21, 2024, Kaiser stopped providing dozens of treatment groups for enrollees with mild to moderate severity SUDs and co-occurring disorders. The canceled treatment groups include, but are not limited to, those listed below. The groups are designed for enrollees with distinct diagnoses and needs. For example, the "Seeking Safety Group" provides group treatment for enrollees with co-occurring PTSD and SUDs. The "Relapse Prevention Group" provides group treatment for enrollees who have completed a higher level of care (such as residential treatment, partial hospitalization programs, and IOPs) and are at risk of relapse.

- Relapse Prevention Group
- Harm Reduction Group

[1] DMHC and Kaiser. Settlement Agreement. October 11, 2023. Paragraphs 69 & 70.

[2] A full-time addiction medicine therapist's caseload is estimated to be approximately 70 enrollees.

- Early Recovery Group
- Seeking Safety Group
- Recovery Maintenance Group

In some cases, due to lack of staffing since October 21, 2024, Kaiser clinics have consolidated two distinct groups designed for separate patient populations into one. In other cases, Kaiser has changed the hours of treatment groups due to its inadequate provider network. For example, prior to October 21, 2024 Kaiser's Relapse Prevention Groups and other treatment groups were typically scheduled to begin after regular working hours (e.g., 6pm) in order to foster enrollee participation. Since October 21, 2024, Kaiser has scheduled groups in some service areas to begin at 4:00pm or 4:30pm, thereby reducing availability of treatment for working enrollees.

Reductions in Group Treatment for Severe SUDs: For enrollees with severe SUDs as well as those with dual diagnoses (i.e., enrollees with a psychiatric disorder and a SUD), Kaiser has reduced its clinical services in multiple service areas. For example, in Kaiser's South Bay service area, Kaiser cut the hours of its Partial Hospitalization Program (PHP) by more than 20 percent. Specifically, it reduced the PHP from 4.5 hours per day for 5 days each week to 3.5 hours per day for 5 days each week. It also reduced the scope of treatment provided to patients in its IOP by eliminating individual psychotherapy that, prior to the work stoppage, was provided concurrently with group IOP treatment.

In the Riverside service area, Kaiser closed its PHP due to the lack of staff after October 21, 2024. Consequently, Kaiser began referring patients to external PHP providers, which has resulted in treatment delays due to Kaiser's inefficient referral process. As a result of the delays, Kaiser has improperly placed some enrollees into IOPs, a lower level of care, even though they require PHP treatment due to the severity of their conditions.

Due to the lack of staff in Kaiser's South Bay service area, Kaiser combined its PHP and IOP into a single group for some period of time after October 21, 2024.

Imposition of Kaiser's Illegal One-Appointment-at-a-Time Rule: In multiple service areas, including but not limited to San Bernadino, Orange County, South Bay, Los Angeles and Woodland Hills, Kaiser continues to impose an illegal non-quantitative treatment limitation (NQTL) on enrollees' SUD care. Specifically, Kaiser employs an appointment-scheduling rule that prohibits enrollees with SUDs and mental health disorders from scheduling multiple individual appointments with their treating clinicians at once despite their individual treatment plans requiring appointments at ongoing, specific frequencies. During the past seven days, NUHW has confirmed that Kaiser continues to impose its illegal appointment-scheduling rule on enrollees with SUDs in the service areas noted above.

The October 11, 2023 DMHC-Kaiser settlement agreement cited Kaiser for this practice as a violation of the Mental Health Parity and Addiction Equity Act.[3] Fourteen months later, Kaiser continues to commit the same violation without consequences, despite NUHW's repeated reports to DMHC that Kaiser's violations continue.

Kaiser's persistent, unmitigated violations raise grave concerns about DMHC's lack of oversight. NUHW first reported Kaiser's illegal, one-appointment-at-a-time rule to DMHC in a formal complaint submitted on November 2, 2018. NUHW submitted additional complaints to DMHC regarding this same practice on October 21, 2019 and June 17, 2021. These complaints are contained in Attachment 1. Each of these complaints provided evidence of Kaiser's violations. Today, more than six years after NUHW first reported Kaiser's violations to DMHC, the violations continue unabated, depriving enrollees of their right to appropriate care.

Understaffing of SUD Care: Prior to October 21, 2024, Kaiser's SUD services were already understaffed in many of its clinics throughout Southern California. During the past 1.5 years, for example, Kaiser's South Bay Addiction Medicine Clinic in Carson has been operating with three vacant positions for addiction medicine counselors, which represent approximately one-quarter of the clinic's total "addiction medicine counselor" positions. Due to these vacancies, addiction medicine counselors are unable to meet enrollees' demand for SUD care. Consequently, the length of its individual appointments for many enrollees has been reduced in half – from 60 minutes to 30 minutes. This reduction in care violates generally accepted standards of care. Since October 21, 2024, understaffing has increased and is compounded by Kaiser's use of untrained and inexperienced temporary staff to provide SUD services.

Untrained and Inexperienced SUD Staff: Kaiser's SUD services are normally provided by therapists trained and experienced in SUDs and addiction medicine. Since the the work stoppage, however, Kaiser has assigned untrained and inexperienced temporary staff to provide SUD services In the Riverside service area, Kaiser assigned a temporary therapist (Ingrid Ann Carr) to lead its PHP and IOP programs even though she has no training or experience in treating SUDs, according to staff accounts as well as her online skills profile. Exhibit A documents Ms. Carr's assignment to this role. While it may be cheaper for Kaiser to hire untrained and inexperienced staff, it results in substandard care.

[3] DMHC and Kaiser. Settlement Agreement. October 11, 2023. Paragraphs 69 & 70.

Exhibit A

Date	Time	Duration	Provider	Department	Type
Monday 12/9					
Mon 12/09/24	9:00 AM	120 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	Day TXT
Mon 12/09/24	11:30 AM	30 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	Virt Remote
Tuesday 12/10					
Tue 12/10/24	8:00 AM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Tue 12/10/24	11:30 AM	30 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Tue 12/10/24	2:30 PM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Tue 12/10/24	3:30 PM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Tue 12/10/24	4:30 PM	30 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	Virt Remote
Tue 12/10/24	5:00 PM	180 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	IOP(1)
Wednesday 12/11					
Wed 12/11/24	8:00 AM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Wed 12/11/24	9:00 AM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Wed 12/11/24	2:30 PM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Wed 12/11/24	4:30 PM	30 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	Virt Remote
Wed 12/11/24	5:00 PM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	IOP(1)
Wed 12/11/24	6:00 PM	120 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	IOP(1)
Thursday 12/12					
Thu 12/12/24	8:00 AM	30 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	
Thu 12/12/24	9:00 AM	120 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	Day TXT
Thu 12/12/24	1:00 PM	120 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	Day TXT
Thu 12/12/24	4:00 PM	60 mins	Carr, Ingrid Ann (Lcsw), L.C.S.W	CDRRIMOR CDR	

Additionally, the temporary staff typically work only two weeks at Kaiser addiction medicine clinics and are not adequately trained in Kaiser's clinical protocols and systems for addiction medicine services, including protocols for diagnosing disorders, assigning levels of care, authorizing outside referrals, transitioning enrollees from one level of care to another, pre- and post-discharge treatment planning, documentation, and others. Furthermore, the temporary staff's two-week-long tenure means Kaiser cannot provide effective individual treatment to enrollees, whose care requires individual therapy for many months. Instead, enrollees are often treated by different temporary therapists at each clinical encounter without the consistency needed to establish an effective therapeutic alliance.

Failure to Perform Assessments and Treatment Planning: Since October 21, 2024, many of Kaiser's SUD clinics have failed to provide patients with required assessments, re-assessments and treatment planning. The following two examples are instructive. When enrollees are transitioned from one level of SUD care to another, Kaiser is required to provide enrollees with a re-assessment of enrollees' SUDs in order to determine their subsequent levels of care and treatment plans. Such re-assessments using ASAM criteria take place, for example, when enrollees are stepped down from residential treatment or PHP care. Due to Kaiser's understaffing of its SUD care since October 21, 2024, many of these re-assessments are not being scheduled or taking place at all. A second example pertains to enrollees undergoing SUD treatment in contracted residential treatment centers. Prior to and after each patient's discharge from such treatment, Kaiser's addiction medicine counselors are required to meet with enrollees in order to establish care plans. Such care planning is critical for preventing relapses. Due to Kaiser's understaffing since October 21, 2024, such treatment planning has not taken place at all for many enrollees.

III. Laws and Analysis

Health plans shall ensure that enrollees are provided with timely behavioral health care services that are consistent with each enrollee’s treatment plan, individualized behavioral health care needs, good professional practice, and timely access standards. Health & Saf. Code, §§ 1367.03, 1374.72; Cal. Code Regs., tit. 28, §§ 1300.70, subds. (a)(3), (b)(1), (b)(2)(G), (b)(2)(H).

Health care service plans must ensure that their networks have adequate capacity and availability of licensed providers to offer enrollees appointments for covered services that meet specific timeframes. Health & Saf. Code, § 1367.03, subd. (a)(5); Cal. Code Regs., tit. 28, § 1300.67.2.2, subd. (c).

California law requires that when it is necessary for a provider or enrollee to reschedule an appointment, the appointment shall be promptly rescheduled in a manner that is appropriate for the enrollee’s health care needs and ensures continuity of care consistent with good professional practice. Additionally, health plans are required to arrange for care from out-of-network providers if timely and geographically accessible care is unavailable from in-network providers. Health and Safety Code §1367.03, subd. (a)(3); 1374.72, subd. (d); California Code of Regulations title 28 sections 1300.67.2.2 (c)(3) and 1300.74.72(c) and (d).

Health plans shall ensure that enrollees do not face barriers to scheduling behavioral health appointments that do not exist for non-behavioral health appointments. Health & Saf. Code, § 1374.72, subd. (a). The same statute requires health plans to cover mental health treatment consistent with generally accepted standards of care.

Health care service plans are required to have procedures in place for continuous review of the quality of care, performance of medical personnel, utilization of services and facilities, and costs. (Health & Saf. Code, § 1370.) To meet DMHC’s requirements for a Quality Assurance program, the program must, in part, continuously review the quality of care provided to ensure that the level of care meets professionally recognized standards of practice, quality of care problems are identified and corrected, and appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason. (Cal. Code Regs., tit. 28, § 1300.70, subd. (b)(1)(A)-(E).)

- § 1300.70(b)(1)(D): Health plans cannot withhold or delay appropriate care from their patients for any reason, "including a potential financial gain and/or incentive."
- § 1300.70(b)(1)(A): Health plans are required to ensure that patients receive "a level of care which meets professionally recognized standards of practice."

- § 1300.70(b)(2)(H)(2): Health plans are required to "detect and correct under-service" by its providers, "including under-utilization of specialist services."
- § 1300.70(a)(1): Health plans must monitor the quality of care provided to its members, identify problems, and take effective action to improve care where deficiencies are identified, including accessibility, availability, and continuity of care. See also § 1300.70(a)(3), § 1300.70(b)(1)(D), § 1300.70(b)(2)(G)(3), §1300.70(c)(1), § 1300.70(c)(5), and § 1300.70(d)(3).
- §1300.74.72 (California Mental Health Parity Act): Health plans that offer coverage for mental health or substance use disorders are required to provide the same level of benefits that they do for general medical treatment.

Kaiser has systematically canceled, reduced and failed to provide both individual and group therapy for enrollees with SUDs across Southern California. In addition, Kaiser continues to impose an illegal NQTL that impairs access to individual therapy for SUDs and mental health disorders. Lastly, Kaiser's violations, including its failure to transition patient caseloads from striking SUD therapists to other staff, represent a severe level of disorganization and failure to maintain effective quality oversight.

III. Request

NUHW requests that DMHC take urgent action to enforce California law and to protect the rights of Kaiser enrollees to obtain timely and appropriate behavioral health services.

NUHW requests that DMHC fulfill its responsibility to enforce our state's laws and to protect the rights of enrollees to receive timely and appropriate care for their mental health and substance use disorders. We request that it order Kaiser to cease and desist from violating California laws, including by imposing an illegal "one-appointment-at-a-time" rule on enrollees with MH/SUDs. We request that DMHC impose significant financial penalties on Kaiser for withholding prescribed care from its enrollees, especially given that Kaiser's actions represent repeat violations for which DMHC cited it one year ago. Lastly, we request that DMHC order Kaiser to reimburse a portion of the monthly premiums to enrollees from whom it has illegally withheld covered services for since October 2024.

Please contact me with any questions or requests.

Sincerely,

Fred Seavey

cc: Rob Bonta, Attorney General
Mike McGuire, Senate President Pro Tempore
Robert Rivas, Speaker of the Assembly
Kim Johnson, Secretary, California Health and Human Services Agency
Kimberly Chen, Acting Deputy Secretary for Program and Fiscal Affairs, CalHHS
Sen. Scott Wiener
Assemblymember Mia Bonta
Sen. Caroline Menjivar
Don Moulds, CalPERS
Dr. Julia Logan, CalPERS

ATTACHMENT 1

NATIONAL UNION OF HEALTHCARE WORKERS

(866) 968-NUHW (6849) ❖ NUHW.org ❖ info@nuhw.org

November 2, 2018

Shelley Rouillard, Director
Dan Southard, Deputy Director—Office of Plan Monitoring
Jennifer E. Marsh, Attorney III —Office of Enforcement
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER FOUNDATION HEALTH PLAN INC. ENFORCEMENT MATTER NOs. 11-543 & 15-082

Dear Ms. Rouillard, Mr. Southard, Ms. Marsh and Mr. Willis:

On behalf of the National Union of Healthcare Workers ("NUHW"), I am writing to provide the Department of Managed Health Care ("DMHC") with evidence of Kaiser Permanente's noncompliance with California law and the DMHC's Cease and Desist Order issued in June of 2013.

At Kaiser's behavioral health clinic in Ventura, Calif., Kaiser employs the following appointment-scheduling rule: At any given time, patients are prohibited from booking more than two successive individual treatment appointments with their non-physician licensed behavioral health provider regardless of a patient's diagnosis or acuity. In order to place a third appointment on the schedule, the patient's treating provider typically must make an individual request for each such appointment to either Anna Garcia, Director of Behavioral Health at Kaiser Woodland Hills Medical Center or, more recently, to her subordinate. Furthermore, if permission is granted, the provider is only permitted to conduct the third appointment during non-patient care periods of the provider's schedule, such as during the provider's limited case-management slots. Patients themselves are not permitted to schedule three or more successive behavioral health appointments regardless of regardless of their diagnosis or acuity.

Our concerns about this appointment-scheduling rule include, but are not limited to, the following:

1. This policy unfairly limits patients' access to Kaiser's behavioral health services. By placing unnecessary appointment-scheduling hurdles in the paths of patients and providers, it has the effect of diminishing patients' access to treatment appointments. The harmful effects of this appointment-setting rule are intensified by the limited availability of behavioral health appointments at the Ventura clinic. Many providers' schedules are completely booked for as many as two months due to the inadequacy of the clinic's provider network. Thus, by

NORTHERN CALIFORNIA
5801 Christie Ave., Suite 525
Emeryville, CA 94608-1986

SOUTHERN CALIFORNIA
225 W. Broadway, Suite 155
Glendale, CA 91204-1332

WASHINGTON, D.C.
1100 Vermont Ave. NW, Suite 1200
Washington, DC 20005-6334

delaying the scheduling of a patient's third appointment until a future point in time, Kaiser forces that patient to endure a lengthier wait for the third appointment than clinically indicated.

2. This policy violates a provision of California law for which Kaiser has already been cited by the DMHC. Specifically, Rule 1300.67.2.2(c)(5)(H) states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See, for example, page 23, page 18 (Footnote 24), page 19, and page 20 of the DMHC's "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services" dated February 24, 2015.
3. This policy contradicts Kaiser's instructions to behavioral health providers issued in February 2015 in conjunction with the DMHC's Follow-up Survey results. On February 23, 2015, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to physician and non-physician behavioral health providers stating, in part, the following (emphasis added): "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**." (See Exhibit I)
4. This policy appears to violate mental health parity laws. Kaiser reportedly places fewer appointment-scheduling restrictions on patients receiving medical and surgical care. For example, Kaiser reportedly does not limit oncology patients to only receive their third chemotherapy appointment during a provider's non-patient treatment hours.
5. This policy appears to violate California Code of Regulations § 1300.67.3, which requires HMOs to ensure that "medical decisions will not be unduly influenced by fiscal and administrative management."

For nearly two years, therapists at Kaiser's Ventura clinic have expressed their objections to this policy in both verbal and written form to multiple Kaiser officials including clinic-based supervisors as well as Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Paul Costaldo (Behavioral Health Care Leader for Kaiser's Southern California Region, SCPMG). Despite these requests, Kaiser has refused to reverse its policy. Kaiser reportedly employs a similar appointment-scheduling rule at other clinic sites, including the Child & Adolescent Program at Woodland Hills.

Exhibit II is an e-mail dated February 26, 2018 entitled "Restriction of Clinical Care" and authored by Dr. Kent Coleman, a Clinical Psychologist practicing at Kaiser's Ventura Medical Office Building. The e-mail is addressed to Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Demetria Mays-Flowers (Reception Supervisor). It is copied to clinical team members and others. The following is an excerpt from the e-mail. The term "case management slots" refers to periods of time in each therapist's schedule that are intended for case management, not direct patient care.[1] In the e-mail, Dr. Coleman references his

over-booked schedule, which is common among many therapists. As of February 23, 2018, the first available open slot in Dr. Coleman's appointment schedule was more than two months later (on May 1). Today, Dr. Coleman's schedule continues to be booked out for a similar amount of time.

> Good Afternoon:
>
> I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments "on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.
>
> Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)] states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner."
>
> Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care.

Exhibit III contains an e-mail dated April 10, 2018 entitled "Patient care issues in Ventura" and authored by Greg Tegenkamp, the Director of NUHW's Kaiser Division. The e-mail is addressed to Paul Costaldo (Behavioral Health Care Leader, SCPMG), who leads Kaiser's behavioral healthcare services across Kaiser's Southern California Region. Mr. Tegenkamp's e-mail includes three attachments. Mr. Costaldo responded verbally to Mr. Tegenkamp's e-mail, stating that clinic managers had a different view of the issue. The clinic's appointment scheduling rule remains unchanged and is in force to this day. Mr. Tegenkamp's e-mail reads as follows:

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

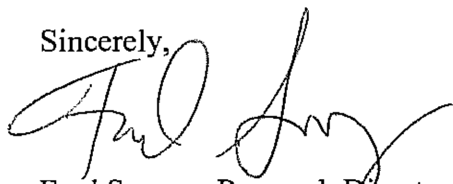
In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

NUHW requests that the DMHC investigate Kaiser's appointment-scheduling rule and its compliance with California laws and regulations. Please contact me with any questions.

Sincerely,



Fred Seavey, Research Director

[1] During an 8-hour workday, a therapist is scheduled to perform 6 hours of direct patient care (i.e., 75% of his/her work hours). The remaining time is designated to be used for case-management duties (1 hour) and patient management time (1 hour). During patient management time, therapists are intended to perform patient charting, make phone calls, write e-mails and letters, prepare for group classes and individual appointment, and perform other non-direct care duties associated with their clinical responsibilities.

Exhibit I

February 23, 2015

Re: DMHC Mental Health Follow-up Survey

Dear Behavioral Medicine Colleagues,

Thank you for all you do every day to care for our members in need of your compassion, caring and expertise. Your dedication to our patients, colleagues and the organization is greatly appreciated. We would like to update you on the Department of Managed Health Care (DMHC) Behavioral Health (BH) Follow-Up Survey. As you are aware, the DMHC surveyed our BH services in 2012-13. Their 2013 BH Final Report included findings regarding capacity, Health Plan oversight and inaccurate member communications. The DMHC then conducted a follow- up survey in 2013-14.

The DMHC Follow-Up Report will be released on Tuesday, February 24, and we want you to know the findings before they are made public. The DMHC has determined that two of the four original deficiencies are resolved and two are not. The DMHC reviewed 297 charts, citing 14 of the 149 charts for SCAL with untimely return access. They also have monitored our monthly access reports and while they noted significant progress, they state there is still inconsistency and lack of stability in access for some Medical Centers.

The DMHC also found three comments within the 297 charts that it identified as inaccurate. One provider inaccurately stated that longer-term therapy is not a covered benefit under the Health Plan and then offered to provide the member with suggestions for low-cost clinics in the community that the member might consider paying for separately. Another provider inaccurately stated that no one ever sees a therapist once a week in the Health Plan and that it was not a covered benefit. Although such statements were only identified in approximately 1 percent of the reviewed medical records, it is important that we provide accurate information to our members.

Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services.

While we are disappointed that the DMHC did not find that all deficiencies were fully corrected, we are also proud of the work you have done to improve and maintain access to Behavioral Health services. The new survey was based on 2013 results and we know that thanks to you, as well as our continued investments in mental health care, our access continued to improve in 2014.

Over the past five years, Southern California has increased staffing by 60 percent; has developed contracts to support therapy access; has enhanced our IOP programs, and taken other meaningful steps to improve our Behavioral Health care delivery. In concert with other Area leaders, we are planning for additional staff and offices for Behavioral Health. We know there is an additional solution to be found and have formed a Behavioral Health Strategy committee to guide that work.

We appreciate your continued commitment to our patients, which is critical in our intent to create the premier behavioral health care delivery model in the country.

Sincerely,

Edward Ellison, MD
Executive Medical Director
Southern California Permanente Medical Group

Benjamin K. Chu, MD, MPH
Regional President
Kaiser Permanente Southern California

Exhibit II

Kent L Coleman <Kent.L.Coleman@kp.org> Mon, Feb 26, 2018 at 1:06 PM
To: Demetria Mays <Demetria.M.Mays-Flowers@kp.org>
Cc: H Anna Garcia <H.Anna.Garcia@kp.org>, Fred Seavey <fseavey@nuhw.org>, "Susan K. Pembroke" <Susan.K.Pembroke@kp.org>, Lisa M Klein <Lisa.M.Klein@kp.org>, Lindsey E Mccormack <Lindsey.E.McCormack@kp.org>, "Katherine D. Cianci" <Katherine.D.Cianci@kp.org>, Cindy L Simental <Cindy.L.Simental@kp.org>, Jessica Bray <Jessica.Bray@kp.org>, Vanesa F Lay <Vanesa.F.Lay@kp.org>, Regina L Isaias <Regina.L.Isaias@kp.org>, Pamela L Chapman <Pam.X.Chapman@kp.org>, Thomas M Letvinchuck <Thomas.M.Letvinchuck@kp.org>, Ilena T Sussman <Ilena.T.Sussman@kp.org>, Sarah M Williams <Sarah.M.Williams@kp.org>, James K Borgeson <James.K.Borgeson@kp.org>, Christine L Johnson <Christine.L.Johnson@kp.org>, "Samantha W. Bookman" <Samantha.W.Bookman@kp.org>

Good Afternoon:

I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments " on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.

Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)} states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. "**

Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care. If for any reason you are unable to effect these changes, please advise. In my meetings with Paul Castaldo he has requested that we try to resolve these type of issues at the local level first. If unable, I will take this to region and DMHC.

I know you care about the patients. If there is anything I can do to facilitate this change let me know as well. Thanks.

Kent L. Coleman PhD

Licensed Clinical Psychologist

Steward/E Board NUHW

Ventura MOB

Exhibit III

Patient care issues in Ventura

1 message

Greg Tegenkamp <gtegenkamp@nuhw.org>
To: Paul Castaldo <Paul.C.Castaldo@kp.org>
Cc: Kent Coleman <drkdangerfield@yahoo.com>

Tue, Apr 10, 2018 at 4:13 PM

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

Thanks,

Greg Tegenkamp
NUHW Kaiser Division Director
gtegenkamp@nuhw.org

3 attachments

DMHC-Follow-UpSurveyResults_2-24-15-1.pdf
811K

KP_SoCal-LetterToClinicians2-23-15.pdf
346K

Coleman-E-mailVenturaMOB_02-26-2018.pdf
65K

NUHW NATIONAL UNION OF HEALTHCARE WORKERS

866-968-NUHW • nuhw.org • info@nuhw.org

October 21, 2019

Shelley Rouillard, Director
Dan Southard, Deputy Director—Office of Plan Monitoring
Jennifer E. Marsh, Attorney III—Office of Enforcement
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER FOUNDATION HEALTH PLAN INC. ENFORCEMENT MATTER NOs. 11-543 & 15-082

Dear Ms. Rouillard, Mr. Southard, Ms. Marsh and Mr. Willis:

On behalf of the National Union of Healthcare Workers ("NUHW"), I am writing to provide the Department of Managed Health Care ("DMHC") with evidence of Kaiser Permanente's noncompliance with California law and the DMHC's Cease and Desist Order issued in June of 2013.

At Kaiser's behavioral health clinic in Bakersfield, Calif., Kaiser employs two appointment-scheduling rules that appear to violate California laws and place enrollees' health and safety at risk.

The first appointment-scheduling rule is the following: At any given time, patients are prohibited from booking more than two successive individual treatment appointments with their non-physician licensed behavioral health provider (hereafter referred to as "therapist" or "therapists") regardless of patients' diagnoses or acuity levels. The second rule prohibits therapists from utilizing all of the future unscheduled appointment slots in their schedules to deliver clinically appropriate treatment to those patients whose conditions require more frequent psychotherapeutic care. Kaiser's managers have communicated these rules both verbally and in written form to the therapists practicing at the clinic.

Exhibit A is an e-mail from Robyn Field (Department Administrator, Behavioral Health Services, Kaiser's Bakersfield clinic) to therapists dated October 15, 2019. The subject line of her email is "Booking appointments" with an importance level of "High." In her e-mail, Ms. Field writes the following (emphasis is in the original).

> Greetings,
>
> Just a reminder that even during these times of challenging access issues, the expectation per DMHC is still that we have Urgent appointments open until 48 hours prior and open intakes within 10 days. **Please refrain from converting intakes to returns and booking more than 2 appointments at a time**. Thank you for taking care of our patients!!
>
> Robyn
> Robyn Field, Ph.D.
> Department Administrator

The second rule — which is referenced in Ms. Field's phrase "please refrain from converting intakes to returns" — requires additional background information. Kaiser structures most therapists' weekly schedules to include both "intake appointments" and "return appointments." "Intakes" are those individual appointments during which therapists perform diagnostic assessments for first-time patients and for patients returning after lengthy lapses in care. Following these diagnostic assessments, therapists deliver treatment to patients during so-called individual "return appointments" or "returns." Kaiser's managers typically place at least 6 to 8 "intakes" in each therapist's weekly schedule.

Many therapists' "return" slots are completely booked for months in advance due to the inadequacy of Kaiser's provider network. Consequently, when a patient requires a more rapid "return appointment" than is available in a therapist's overloaded schedule, the therapist has little to no ability to deliver such an appointment. For example, a patient with Major Depressive Disorder may exhibit suicidal ideation during an appointment with his/her therapist, requiring the therapist to schedule the patient for a subsequent individual appointment during the following week. Since all of the therapist's future "return appointments" are already booked for the next two months, the therapist attempts to use a future unscheduled "intake" slot to provide a "return appointment" to the patient.

As noted in Ms. Field's e-mail, Kaiser's managers prohibit therapists from converting future unscheduled "intakes" to "returns." This appointment-setting rule, in combination with Kaiser's inadequate provider network and its "patients-can-only-book-two-appointments-at-a-time" rule, improperly prohibit enrollees from obtaining clinically appropriate care consistent with their diagnoses and conditions.

In a September 2013 complaint to the DMHC, NUHW documented Kaiser's second appointment-setting rule and its harmful effect on Kaiser's enrollees. The complaint contained a Kaiser psychologist's e-mail message to her managers. The psychologist, who practiced at Kaiser's mental health clinic in Oakland, Calif., reported to her managers that she could not deliver clinically appropriate care to her patients given that all of her return appointments were

booked for the next five months. She writes, "I can't tell a patient with 3-6 months to live that I'll see them [for their next appointment] in 5 months." She continues:

> "These patients need access to follow-up care. I can't neglect, abandon, or marginalize these patients. They are ill and often facing mortality. They need to be able to return within weeks and then have, at a minimum, biweekly follow-up visits on a regular basis. These patients need, deserve, and frankly pay for, better service."

In her email, she reports to her managers that she has chosen to violate Kaiser's second appointment-setting rule due to her patients' needs. She writes: "Out of desperation, since I believe I am unable to provide a course of treatment that's indicated by patients' conditions, I have converted new appointment slots to return appointments." In therapists' lexicon, the term "new appointment" is synonymous with "intake appointments." Despite her effort to transparently communicate to Kaiser's managers her rationale for converting some of her future "intakes" to "returns," the psychologist was nonetheless subjected to disciplinary action by Kaiser's managers for violating the company's second appointment-setting rule. See Exhibit B for NUHW's September 2013 complaint.

In a separate complaint (filed November 2, 2018), NUHW documented Kaiser's first appointment-setting rule. The complaint provided documentary evidence detailing Kaiser's rule at its behavioral health clinic in Ventura, Calif. that prohibited enrollees from booking more than two successive individual treatment appointments with their therapist regardless of the enrollee's diagnosis or acuity. (Exhibit C)

Our concerns about Kaiser's appointment-scheduling rules include, but are not limited to, the following:

1. Kaiser's two rules unfairly limit patients' access to Kaiser's behavioral health services. By placing unnecessary appointment-scheduling hurdles in the paths of patients and providers, Kaiser improperly restricts patients' access to clinically appropriate treatment appointments. These rules' harmful effects are intensified by the limited availability of behavioral health appointments at the Bakersfield clinic. Most providers' schedules are completely booked for at least two to three months due to the inadequacy of the clinic's provider network. Thus, by preventing an enrollee from scheduling a third appointment until a future date per its "patients-can-only-book-two-appointments-at-a-time" rule, Kaiser typically forces enrollees to endure more lengthy waits for third appointments than are clinically indicated.
2. Kaiser's "patients-can-only-book-two-appointments-at-a-time" rule violates a provision of California law for which Kaiser has already been cited by the DMHC. Specifically, Rule 1300.67.2.2(c)(5)(H) states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See, for example, page 23, page

18 (Footnote 24), page 19, and page 20 of the DMHC's "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services" dated February 24, 2015.

3. Kaiser's two rules contradict the instructions it delivered to therapists in February 2015 in conjunction with the DMHC's Follow-up Survey results. On February 23, 2015, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to physician and non-physician behavioral health providers stating, in part, the following (emphasis added): "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**." (See Exhibit D)

4. Kaiser's two rules contradict its recent claims to the American Psychological Association (APA) regarding the availability of mental health treatment appointments for Kaiser's enrollees. On September 16, 2019, Kaiser's Robin Betts (VP of Quality, Clinical Effectiveness & Regulatory Services, KFHP, Northern California Region) and Patti Harvey (Senior VP of Quality, Regulatory & Clinical Operation Support, KFHP, Northern California Region) sent a six-page letter to the APA in response to an earlier letter from dozens of Kaiser's psychologists to the APA describing how Kaiser's systematic treatment delays violate professionally recognized standards of practice established by the APA. (See Exhibit E.) In their letter, Ms. Betts and Ms. Harvey state that "clinicians have complete autonomy to select and design appropriate treatment plans using evidence-based guidelines, including duration and frequency of treatment. If a clinician faces any barrier in implementing their chosen treatment plant, then they are counseled and supported by their respective clinical department managers, who will assist in removing the barrier, including creating capacity." (p. 4) Their letter continues: "Treatment planning is individualized at the clinician and patient level. Clinicians make the determination of best practices and medical necessity for modality of care, type of intervention, roles, and frequency of return follow-up." (p. 3) "If ongoing individual therapy is needed over a prolonged period for any patient, or the clinician is having difficulty implementing effective treatment for any reason, department managers assist in removing barriers and creating any needed capacity." (p. 4) Kaiser's arbitrary restrictions on scheduling appointments fly in the face of the aforementioned claims by Kaiser's top executives to the APA, a national standard-setting organization.

5. Kaiser's two rules appear to violate mental health parity laws. Kaiser reportedly places fewer appointment-scheduling restrictions on patients receiving medical and surgical care. For example, Kaiser does not force oncology patients to book only two future chemotherapy appointments at a time. Why, then, does Kaiser impose arbitrary restrictions on enrollees who seek psychotherapy appointments for depression, bipolar disorder, schizophrenia, schizoaffective disorder and other diagnoses?

6. Kaiser's two rules appear to violate California Code of Regulations § 1300.67.3, which requires HMOs to ensure that "medical decisions will not be unduly influenced by fiscal and administrative management."

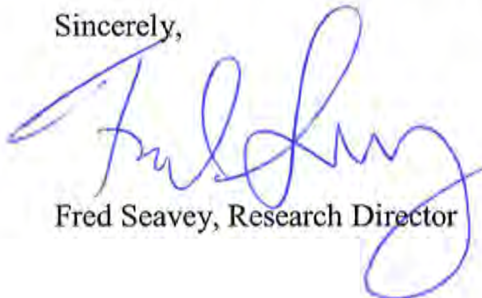
As noted above, therapists have expressed their objections to these policies to multiple Kaiser officials. Nonetheless, Kaiser has refused to correct its policies.

Furthermore, when NUHW formally brought this issue to the attention of Kaiser's regional executives more than one year ago, these officials refused to correct Kaiser's improper practices. Exhibit F contains an e-mail dated April 10, 2018 entitled "Patient care issues in Ventura" and authored by Greg Tegenkamp, the Director of NUHW's Kaiser Division. The e-mail is addressed to Paul Castaldo (Behavioral Health Care Leader, SCPMG), who served as "Regional Leader" of Behavioral Health Care for Kaiser's Southern California Region. Mr. Tegenkamp's e-mail includes three attachments. Mr. Castaldo responded verbally to Mr. Tegenkamp's e-mail, stating that clinic managers had a different view of the issue. The clinic's appointment scheduling rule remained unchanged, which prompted NUHW to submit complaint to the DMHC on November 2, 2018.

Lastly, NUHW is concerned about the DMHC's apparent failure to enforce California laws and regulations on Kaiser, our state's largest HMO. In February of 2015, the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H). Nearly five years later, Kaiser continues to violate this rule. Furthermore, Kaiser's violations at its Bakersfield clinic are taking place nearly one year after NUHW filed a detailed complaint to the DMHC regarding this same practice at Kaiser's mental health clinic in Ventura, California. We are extremely concerned that Kaiser appears determined to disregard not only California's rules and standards, but also any enforcement authority exercised by the DMHC. With nine million enrollees in California, Kaiser should not be permitted to disregard our state's laws with impunity. Furthermore, our state's regulator should be taking every reasonable step to ensure compliance by a serial violator of state laws and regulations.

NUHW requests that the DMHC (1) immediately investigate Kaiser's appointment-scheduling rules and (2) apply enhanced sanctions against Kaiser for any violations given the plan's repeated violation of California laws and regulations and its failure to correct these violations over many years. Please contact me with any questions.

Sincerely,



Fred Seavey, Research Director

EXHIBIT A

From: Robyn L. Field <Robyn.L.Field@kp.org>
Sent: Tuesday, October 15, 2019 7:38 AM
To

Subject: Booking appointments
Importance: High

Greetings,

Just a reminder that even during these times of challenging access issues, the expectation per DMHC is still that we have Urgent appointments open until 48 hours prior and open intakes within 10 days. **Please refrain from converting intakes to returns and booking more than 2 appointments at a time**. Thank you for taking care of our patients!!

Robyn

Robyn Field, Ph.D.
Department Administrator
Robyn.L.Field@kp.org

Kaiser Permanente
Behavioral Health Services
Psychiatry, Addiction Medicine, Social Medicine
4900 California Ave., Tower A, Suite 200
Bakersfield, CA 93309

(661)852-2883 (office)
8-352-2883 (tie-line)
Ruben Foster (assistant)
Ruben.A.Foster@kp.org
(661) 852-2746
kp.org/thrive

EXHIBIT B

September 16, 2013

Carol Ventura, Deputy Director – Office of Enforcement
Shelly Rouillard, Chief Deputy Director
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER PERMANENTE ENFORCEMENT MATTER NO: 11-543; ACCESS CRISIS AT OAKLAND PSYCHIATRY DEPARTMENT

Dear Ms. Ventura, Ms. Rouillard and Mr. Willis:

On behalf of NUHW, I'm writing to provide the DMHC with additional information regarding Kaiser Permanente's ongoing noncompliance with California's Timely Access regulations and other standards. As NUHW has done in the past, I'm attaching documentation regarding the wait times experienced by enrollees seeking mental health care.

A. Access Crisis at Oakland Psychiatry Department

Exhibit A contains an email message from Melinda Ginne, PhD (a licensed Psychologist who practices at Kaiser's Oakland Psychiatry Department) to Ana Sukiennik-Takaoka, Ph.D. (Manager of the department's Adult Services) and David Atkins, MD (the Sub-Chief of the department's Adult Services). The email is dated September 11, 2013.

According to her profile on Kaiser's website, Dr. Ginne is a "Behavioral Medicine Specialist" who treats "patients who have both a medical and psychological concern - for example, diabetes and depression, heart disease and anxiety, or migraine headache and stress." She is also a Geriatric Specialist and "diagnose[s] and treat[s] mental health concerns of aging such as late-life depression, anxiety, post-stroke syndrome, vascular dementia, and Alzheimer's disease." Dr. Ginne first began working at Kaiser in 1980.

Dr. Ginne's email indicates that many of her patients are currently facing severe access problems that violate California's laws and regulations, including the "clinical appropriateness standard." The following are several excerpts from Dr. Ginne's email.

> "As the only Gero-psychologist and the only Behavioral Medicine clinician still left at Kaiser Oakland, the bulk of my caseload is seriously ill medical patients and frail

elderly. Because of the lack of follow-up availability, my patients have been waiting 3 months for a routine follow-up appointment. This has been a dire situation with often adverse consequences for the patients. But now they must wait 5 months.

"Not only are they facing life-altering medical problems but they are being implicitly told that the care they need at Kaiser is unavailable.

"In the past 6-12 months my return access has become more compromised and the return dates are farther out, resulting in my first available return appointment now into the middle of January, 2014. Believe me, I can't tell a patient with 3-6 months to live that I'll see them in 5 months. I can't tell a family whose elderly mother is declining that I can't provide treatment until 2014…

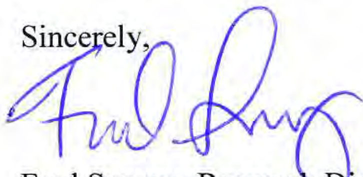
"These patients need access to follow-up care. I can't neglect, abandon, or marginalize these patients. They are ill and often facing mortality. They need to be able to return within weeks and then have, at minimum, biweekly follow-up visits on a regular basis. These patients need, deserve, and frankly pay for, better service…

"More importantly, I don't believe the department is providing clinically appropriate care for these medical patients that used to be treated by a team of Behavioral Medicine Specialists. It is unreasonable and imprudent to triage these patients to the other mental health providers in the department since they do not have training or experience in geriatrics or in treating the psychological aspects of medical illness…

"Although I brought this up over a year ago, the situation has continued to worsen. I now need to enlist your help to immediately rectify this problem. We just can't continue to fail these patients."

We request that the DMHC investigate the crisis in access described by Dr. Ginne. I would be happy to answer any questions you might have.

Sincerely,



Fred Seavey, Research Director

Attachment

ATTACHMENT A

From: Melinda Ginne/CA/KAIPERM
To: Ana V Sukiennik-Takaoka/CA/KAIPERM@Kaiperm, David A Atkins/CA/KAIPERM@Kaiperm
Cc: Clement Papazian/CA/KAIPERM@KAIPERM, Andris Skuja/CA/KAIPERM@KAIPERM
Date: 09/11/2013 03:01 PM
Subject: return access

Ana Sukiennik-Takaoka, Ph.D. Manager, Adult Service
David Atkins, MD Sub-Chief Adult Service

Dear Ana and David,

September 11, 2013

I am writing to you on behalf of the many patients I see who are sick, frail, and disabled. These patients are suffering, scared, and vulnerable. They need time and attention to process their feelings, to come to terms with their diagnosis and all of its ramifications, to make medical decisions, to adapt their lives, to make arrangements for their family, and to cope with the significant issues that their loved ones are going through.

As the only Gero-psychologist and the only Behavioral Medicine clinician still left at Kaiser Oakland, the bulk of my caseload is seriously ill medical patients and frail elderly. Because of the lack of follow-up availability, my patients have been waiting 3 months for a routine follow-up appointment. This has been a dire situation with often adverse consequences for the patients. But now they must wait 5 months.

Not only are they facing life-altering medical problems but they are being implicitly told that the care they need at Kaiser is unavailable.

In the past 6-12 months my return access has become more compromised and the return dates are farther out, resulting in my first available return appointment now into the middle of January, 2014. Believe me, I can't tell a patient with 3-6 months to live that I'll see them in 5 months. I can't tell a family whose elderly mother is declining that I can't provide treatment until 2014.

In the past, my Behavioral Medicine colleagues and I would have seen patients like this several visits and then enrolled them in a Behavioral Medicine treatment specific group. With the dismantling of the Behavioral Medicine Service the groups are gone and because of the lack of return appointments in my schedule I often can't encourage even a single follow up visit.

These patients need access to follow-up care. I can't neglect, abandon, or marginalize these patients. They are ill and often facing mortality. They need to be able to return

within weeks and then have, at minimum, biweekly follow-up visits on a regular basis. These patients need, deserve, and frankly pay for, better service.

My schedule needs to be revised immediately. Without drastic changes to my schedule I'm unable to provide a course of treatment that's indicated by these patients' high acuity conditions.

More importantly, I don't believe the department is providing clinically appropriate care for these medical patients that used to be treated by a team of Behavioral Medicine Specialists. It is unreasonable and imprudent to triage these patients to the other mental health providers in the department since they do not have training or experience in geriatrics or in treating the psychological aspects of medical illness.

Although this seems to be a broken system that needs radical revision, I have tried several strategies to manage the return demand. I have booked patients into slots that are reserved for meetings, staff education, or practice management time. I have changed phone appointment slots to appointment types I can convert into a return appointment. I often make my call backs during lunch, in fact, the only lunch break I get during the week, is on Wednesdays, otherwise I'm at my desk working.

Out of desperation, since I believe I am unable to provide a course of treatment that's indicated by patients' conditions, I have at times converted new appointment slots to return appointments. In making this decision, I gave consideration to my professional and ethical responsibilities, potential liability to Kaiser, and the risks to the patients with whom I had already entered into a therapeutic relationship. I believe, in the instances when I converted news to returns, my concerns for my existing patients outweighed concerns for patients I had not yet met. Having to chose between seeing new or return patients is not a decision any clinician should have to make. But due to inadequate staffing, the demise of behavioral medicine, and the ethical obligation I feel toward these patients, I have been forced into this position.

Although I brought this up over a year ago, the situation has continued to worsen. I now need to enlist your help to immediately rectify this problem. We just can't continue to fail these patients.

Sincerely,

Melinda

Melinda Ginne, Ph.D.
Behavioral Medicine
Gero-psychology
Kaiser-Oakland

3900 Broadway
Oakland, CA 94611
Tele: (510) 752-8302
Tie : 8-492-8302
FAX: (510) 752-6722
Hours: M, W-F

There is more to life than increasing its speed - Gandhi

EXHIBIT C

(866) 968-NUHW (6849) ❖ NUHW.org ❖ info@nuhw.org

November 2, 2018

Shelley Rouillard, Director
Dan Southard, Deputy Director—Office of Plan Monitoring
Jennifer E. Marsh, Attorney III —Office of Enforcement
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER FOUNDATION HEALTH PLAN INC. ENFORCEMENT MATTER NOs. 11-543 & 15-082

Dear Ms. Rouillard, Mr. Southard, Ms. Marsh and Mr. Willis:

On behalf of the National Union of Healthcare Workers ("NUHW"), I am writing to provide the Department of Managed Health Care ("DMHC") with evidence of Kaiser Permanente's noncompliance with California law and the DMHC's Cease and Desist Order issued in June of 2013.

At Kaiser's behavioral health clinic in Ventura, Calif., Kaiser employs the following appointment-scheduling rule: At any given time, patients are prohibited from booking more than two successive individual treatment appointments with their non-physician licensed behavioral health provider regardless of a patient's diagnosis or acuity. In order to place a third appointment on the schedule, the patient's treating provider typically must make an individual request for each such appointment to either Anna Garcia, Director of Behavioral Health at Kaiser Woodland Hills Medical Center or, more recently, to her subordinate. Furthermore, if permission is granted, the provider is only permitted to conduct the third appointment during non-patient care periods of the provider's schedule, such as during the provider's limited case-management slots. Patients themselves are not permitted to schedule three or more successive behavioral health appointments regardless of regardless of their diagnosis or acuity.

Our concerns about this appointment-scheduling rule include, but are not limited to, the following:

1. This policy unfairly limits patients' access to Kaiser's behavioral health services. By placing unnecessary appointment-scheduling hurdles in the paths of patients and providers, it has the effect of diminishing patients' access to treatment appointments. The harmful effects of this appointment-setting rule are intensified by the limited availability of behavioral health appointments at the Ventura clinic. Many providers' schedules are completely booked for as many as two months due to the inadequacy of the clinic's provider network. Thus, by

delaying the scheduling of a patient's third appointment until a future point in time, Kaiser forces that patient to endure a lengthier wait for the third appointment than clinically indicated.

2. This policy violates a provision of California law for which Kaiser has already been cited by the DMHC. Specifically, Rule 1300.67.2.2(c)(5)(H) states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See, for example, page 23, page 18 (Footnote 24), page 19, and page 20 of the DMHC's "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services" dated February 24, 2015.
3. This policy contradicts Kaiser's instructions to behavioral health providers issued in February 2015 in conjunction with the DMHC's Follow-up Survey results. On February 23, 2015, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to physician and non-physician behavioral health providers stating, in part, the following (emphasis added): "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**." (See Exhibit I)
4. This policy appears to violate mental health parity laws. Kaiser reportedly places fewer appointment-scheduling restrictions on patients receiving medical and surgical care. For example, Kaiser reportedly does not limit oncology patients to only receive their third chemotherapy appointment during a provider's non-patient treatment hours.
5. This policy appears to violate California Code of Regulations § 1300.67.3, which requires HMOs to ensure that "medical decisions will not be unduly influenced by fiscal and administrative management."

For nearly two years, therapists at Kaiser's Ventura clinic have expressed their objections to this policy in both verbal and written form to multiple Kaiser officials including clinic-based supervisors as well as Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Paul Costaldo (Behavioral Health Care Leader for Kaiser's Southern California Region, SCPMG). Despite these requests, Kaiser has refused to reverse its policy. Kaiser reportedly employs a similar appointment-scheduling rule at other clinic sites, including the Child & Adolescent Program at Woodland Hills.

Exhibit II is an e-mail dated February 26, 2018 entitled "Restriction of Clinical Care" and authored by Dr. Kent Coleman, a Clinical Psychologist practicing at Kaiser's Ventura Medical Office Building. The e-mail is addressed to Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Demetria Mays-Flowers (Reception Supervisor). It is copied to clinical team members and others. The following is an excerpt from the e-mail. The term "case management slots" refers to periods of time in each therapist's schedule that are intended for case management, not direct patient care.[1] In the e-mail, Dr. Coleman references his

over-booked schedule, which is common among many therapists. As of February 23, 2018, the first available open slot in Dr. Coleman's appointment schedule was more than two months later (on May 1). Today, Dr. Coleman's schedule continues to be booked out for a similar amount of time.

> Good Afternoon:
>
> I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments "on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.
>
> Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)] states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner."
>
> Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care.

Exhibit III contains an e-mail dated April 10, 2018 entitled "Patient care issues in Ventura" and authored by Greg Tegenkamp, the Director of NUHW's Kaiser Division. The e-mail is addressed to Paul Costaldo (Behavioral Health Care Leader, SCPMG), who leads Kaiser's behavioral healthcare services across Kaiser's Southern California Region. Mr. Tegenkamp's e-mail includes three attachments. Mr. Costaldo responded verbally to Mr. Tegenkamp's e-mail, stating that clinic managers had a different view of the issue. The clinic's appointment scheduling rule remains unchanged and is in force to this day. Mr. Tegenkamp's e-mail reads as follows:

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

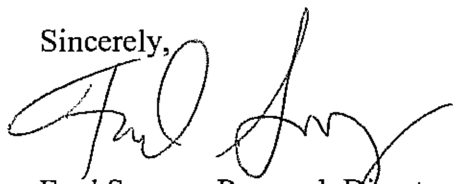
In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

NUHW requests that the DMHC investigate Kaiser's appointment-scheduling rule and its compliance with California laws and regulations. Please contact me with any questions.

Sincerely,



Fred Seavey, Research Director

[1] During an 8-hour workday, a therapist is scheduled to perform 6 hours of direct patient care (i.e., 75% of his/her work hours). The remaining time is designated to be used for case-management duties (1 hour) and patient management time (1 hour). During patient management time, therapists are intended to perform patient charting, make phone calls, write e-mails and letters, prepare for group classes and individual appointment, and perform other non-direct care duties associated with their clinical responsibilities.

Exhibit I

February 23, 2015

Re: DMHC Mental Health Follow-up Survey

Dear Behavioral Medicine Colleagues,

Thank you for all you do every day to care for our members in need of your compassion, caring and expertise. Your dedication to our patients, colleagues and the organization is greatly appreciated. We would like to update you on the Department of Managed Health Care (DMHC) Behavioral Health (BH) Follow-Up Survey. As you are aware, the DMHC surveyed our BH services in 2012-13. Their 2013 BH Final Report included findings regarding capacity, Health Plan oversight and inaccurate member communications. The DMHC then conducted a follow- up survey in 2013-14.

The DMHC Follow-Up Report will be released on Tuesday, February 24, and we want you to know the findings before they are made public. The DMHC has determined that two of the four original deficiencies are resolved and two are not. The DMHC reviewed 297 charts, citing 14 of the 149 charts for SCAL with untimely return access. They also have monitored our monthly access reports and while they noted significant progress, they state there is still inconsistency and lack of stability in access for some Medical Centers.

The DMHC also found three comments within the 297 charts that it identified as inaccurate. One provider inaccurately stated that longer-term therapy is not a covered benefit under the Health Plan and then offered to provide the member with suggestions for low-cost clinics in the community that the member might consider paying for separately. Another provider inaccurately stated that no one ever sees a therapist once a week in the Health Plan and that it was not a covered benefit. Although such statements were only identified in approximately 1 percent of the reviewed medical records, it is important that we provide accurate information to our members.

Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services.

While we are disappointed that the DMHC did not find that all deficiencies were fully corrected, we are also proud of the work you have done to improve and maintain access to Behavioral Health services. The new survey was based on 2013 results and we know that thanks to you, as well as our continued investments in mental health care, our access continued to improve in 2014.

Over the past five years, Southern California has increased staffing by 60 percent; has developed contracts to support therapy access; has enhanced our IOP programs, and taken other meaningful steps to improve our Behavioral Health care delivery. In concert with other Area leaders, we are planning for additional staff and offices for Behavioral Health. We know there is an additional solution to be found and have formed a Behavioral Health Strategy committee to guide that work.

We appreciate your continued commitment to our patients, which is critical in our intent to create the premier behavioral health care delivery model in the country.

Sincerely,

Edward Ellison, MD
Executive Medical Director
Southern California Permanente Medical Group

Benjamin K. Chu, MD, MPH
Regional President
Kaiser Permanente Southern California

Exhibit II

Kent L Coleman <Kent.L.Coleman@kp.org> Mon, Feb 26, 2018 at 1:06 PM
To: Demetria Mays <Demetria.M.Mays-Flowers@kp.org>
Cc: H Anna Garcia <H.Anna.Garcia@kp.org>, Fred Seavey <fseavey@nuhw.org>, "Susan K. Pembroke" <Susan.K.Pembroke@kp.org>, Lisa M Klein <Lisa.M.Klein@kp.org>, Lindsey E Mccormack <Lindsey.E.McCormack@kp.org>, "Katherine D. Cianci" <Katherine.D.Cianci@kp.org>, Cindy L Simental <Cindy.L.Simental@kp.org>, Jessica Bray <Jessica.Bray@kp.org>, Vanesa F Lay <Vanesa.F.Lay@kp.org>, Regina L Isaias <Regina.L.Isaias@kp.org>, Pamela L Chapman <Pam.X.Chapman@kp.org>, Thomas M Letvinchuck <Thomas.M.Letvinchuck@kp.org>, Ilena T Sussman <Ilena.T.Sussman@kp.org>, Sarah M Williams <Sarah.M.Williams@kp.org>, James K Borgeson <James.K.Borgeson@kp.org>, Christine L Johnson <Christine.L.Johnson@kp.org>, "Samantha W. Bookman" <Samantha.W.Bookman@kp.org>

Good Afternoon:

I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments " on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.

Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)} states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. "**

Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care. If for any reason you are unable to effect these changes, please advise. In my meetings with Paul Castaldo he has requested that we try to resolve these type of issues at the local level first. If unable, I will take this to region and DMHC.

I know you care about the patients. If there is anything I can do to facilitate this change let me know as well. Thanks.

Kent L. Coleman PhD

Licensed Clinical Psychologist

Steward/E Board NUHW

Ventura MOB

Exhibit III

Patient care issues in Ventura

1 message

Greg Tegenkamp <gtegenkamp@nuhw.org>
To: Paul Castaldo <Paul.C.Castaldo@kp.org>
Cc: Kent Coleman <drkdangerfield@yahoo.com>

Tue, Apr 10, 2018 at 4:13 PM

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

Thanks,

Greg Tegenkamp
NUHW Kaiser Division Director
gtegenkamp@nuhw.org

3 attachments

DMHC-Follow-UpSurveyResults_2-24-15-1.pdf
811K

KP_SoCal-LetterToClinicians2-23-15.pdf
346K

Coleman-E-mailVenturaMOB_02-26-2018.pdf
65K

EXHIBIT D

February 23, 2015

Re: DMHC Mental Health Follow-up Survey

Dear Behavioral Medicine Colleagues,

Thank you for all you do every day to care for our members in need of your compassion, caring and expertise. Your dedication to our patients, colleagues and the organization is greatly appreciated. We would like to update you on the Department of Managed Health Care (DMHC) Behavioral Health (BH) Follow-Up Survey. As you are aware, the DMHC surveyed our BH services in 2012-13. Their 2013 BH Final Report included findings regarding capacity, Health Plan oversight and inaccurate member communications. The DMHC then conducted a follow- up survey in 2013-14.

The DMHC Follow-Up Report will be released on Tuesday, February 24, and we want you to know the findings before they are made public. The DMHC has determined that two of the four original deficiencies are resolved and two are not. The DMHC reviewed 297 charts, citing 14 of the 149 charts for SCAL with untimely return access. They also have monitored our monthly access reports and while they noted significant progress, they state there is still inconsistency and lack of stability in access for some Medical Centers.

The DMHC also found three comments within the 297 charts that it identified as inaccurate. One provider inaccurately stated that longer-term therapy is not a covered benefit under the Health Plan and then offered to provide the member with suggestions for low-cost clinics in the community that the member might consider paying for separately. Another provider inaccurately stated that no one ever sees a therapist once a week in the Health Plan and that it was not a covered benefit. Although such statements were only identified in approximately 1 percent of the reviewed medical records, it is important that we provide accurate information to our members.

Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services.

While we are disappointed that the DMHC did not find that all deficiencies were fully corrected, we are also proud of the work you have done to improve and maintain access to Behavioral Health services. The new survey was based on 2013 results and we know that thanks to you, as well as our continued investments in mental health care, our access continued to improve in 2014.

Over the past five years, Southern California has increased staffing by 60 percent; has developed contracts to support therapy access; has enhanced our IOP programs, and taken other meaningful steps to improve our Behavioral Health care delivery. In concert with other Area leaders, we are planning for additional staff and offices for Behavioral Health. We know there is an additional solution to be found and have formed a Behavioral Health Strategy committee to guide that work.

We appreciate your continued commitment to our patients, which is critical in our intent to create the premier behavioral health care delivery model in the country.

Sincerely,

Edward Ellison, MD
Executive Medical Director
Southern California Permanente Medical Group

Benjamin K. Chu, MD, MPH
Regional President
Kaiser Permanente Southern California

EXHIBIT E

September 16, 2019

SENT VIA ELECTRONIC MAIL TO: ANessman@apa.org

Alan Nessman, JD – Senior Special Counsel, Legal & Regulatory Affairs
American Psychological Association
Practice Directorate
750 First St. NE
Washington, DC 20002-4242

RE: ***June 3, 2019 Letter from National Union of Healthcare Workers/APA Members***

Dear Mr. Nessman:

Thank you for your recent inquiry prompted by the June 3, 2019 letter from certain National Union of Healthcare Workers ("NUWH") and APA members ("NUHW Letter") expressing concerns regarding Kaiser Permanente members' access to timely and appropriate mental health services in California. We appreciate the opportunity to provide a response.

We agree that every Kaiser Permanente member – and in fact every American – should have access to high-quality mental health care when they need it. This is one of the top health care priorities of our day. Kaiser Permanente is at the forefront of meeting this challenge head on and we are getting results thanks to the dedication of our mental health teams. This includes our frontline clinicians in California represented by the NUHW, which we have been in contract negotiations with for more than a year.

The NUHW Letter is part of an ongoing public pressure campaign by NUHW leadership to try and pressure Kaiser Permanente management to agree to their financial demands in bargaining. We have urged NUHW's leadership to bargain constructively and stop putting our patients in the middle of their contract demands. The NUHW Letter is a clear attempt to drag the APA into the NUHW's corporate campaign. Despite the NUHW's tactics, Kaiser Permanente remains committed to responsibly reaching a new contract agreement, which is what our therapists and patients deserve.

Below we provide an overview of Kaiser Permanente's commitment to ensuring access to timely and appropriate mental health services in our two California regions. We also respond to the unfounded allegations raised in the NUHW Letter.

Kaiser Permanente California – Mental Health Services

Kaiser Permanente Northern California is the only health plan in the state to earn 5 stars – the highest possible rating – for behavioral and mental health care access and quality according to the California Office of the Patient Advocate (OPA) 2018 Report Card. Kaiser Permanente Southern California is one of only three plans in the state to receive the Report Card's next highest possible rating.

Still, we know that all mental health care providers — including Kaiser Permanente — have work to do to improve. We have a broad range of initiatives designed to increase access, continually improve and set a new standard of service excellence. They include:

- **Improved Quality Oversight.** Kaiser Permanente is committed to timely access, and we continue to improve our performance in meeting or exceeding the established regulatory standard for first appointments for behavioral health. We actively monitor and review the quality and service levels for behavioral health services, providing feedback on gaps in performance and the need to perform to plan. This includes auditing of triage assessment documentation for initial behavioral health appointments booked beyond regulatory guidelines. We continue auditing individual provider treatment plans to ensure follow-up appointments are offered at return intervals consistent with the patient's treatment plan. When a site is out of compliance, we ensure that corrective action plans ("CAPs") document the root cause analysis and corrective action interventions. And, we continue to refine the escalation process, enhance interventions, and employ best practices to make progress with sites that are out of compliance.

- **Adding More Resources:** In its February 2019 report on the overall shortage of health professionals in California, the California Future Health Workforce Commission states that unless the state makes dramatic policy changes, "California will have 41% fewer psychiatrists and 11% fewer psychologists, marriage and family therapists, clinical counselors, and social workers than it will need." Despite the national and state shortage of trained mental health professionals, Kaiser Permanente has hired more than 1,100 new therapists and filled more than 2,600 mental health positions in California from 2016 through present, and we continue to hire more (also see "Growing the Workforce" below). Through our integrated delivery model, our members are offered and receive comprehensive mental health services in settings where they are and where they want to receive care.

- **More Treatment Locations:** We are accelerating our ongoing $700-million project to expand and enhance our mental health care treatment facilities, with the goal of making mental health care more available and improving access in environments that offer our patients convenience, comfort and privacy.

- **Embedding Mental Health Care in Primary Care:** Our primary care and mental health providers work together to make mental health and wellness part of a patient's total health. We are making it possible for members to receive mental health care throughout our organization, including embedding mental health professionals in primary care clinics and emergency departments.

- **Innovative Options:** Our use of innovative technology is growing rapidly, driven by the preferences of our patients for ease of access and convenience. On an annual basis, we provide hundreds of thousands of tele-health visits statewide, allowing patients to communicate with their therapists from the privacy and comfort of their homes.

- **Growing the Workforce:** We provide an extensive array of training opportunities statewide for more than 300 trainees each year, including residency training programs in psychiatry in Northern and Southern California, and training opportunities and assistantships for post-masters and pre- and post-doctoral level mental health providers. We are moving forward with several initiatives totaling $50 million that will increase the number of people who are entering mental health professions. This includes tuition assistance for our current employees, fellowships and residencies for future hires, and grants to expand capacity in degree programs, with an emphasis in graduating bilingual and/or diverse students who reflect community needs. We are also committing $6 million to encourage our therapists' engagement in clinical research to further develop evidence-based treatment and outcomes.

- **Designing the Future of Care:** We've proposed creating an intensive work group of therapists and management, to advance innovation and evidence-based practice in our model of care. We believe – as do our therapists – that the dramatic increase in mental health care demand cannot be fully met without changes in the way mental health services are provided. We are reimagining the continuum of mental health and addiction care to incorporate opportunities afforded by new technologies, the use of collaborative care in primary care, and by rigorously applying the evidence base of what works in specialty care. This new continuum will allow us to serve the mental health needs of our population in new and even more effective ways.

- **Reducing Stigma:** Kaiser Permanente is committed to reducing stigma associated with mental health treatment. For example, in 2016, Kaiser Permanente launched the national "Find Your Words" public health awareness campaign (findyourwords.org), joining forces with others in the field to spark a national conversation about depression. This is one of several national initiatives we have launched to help reduce the stigma that can be a personal barrier to reaching out for mental health support.

Allegations in NUHW Letter

The NUHW Letter alleges Kaiser Permanente has violated professionally recognized standards of practice in delivery mental health services. Each allegation is separately addressed below.

1. **Kaiser Permanente's Northern California and Southern California Behavioral Health Clinics are meeting timely access requirements in compliance with professionally recognized standards of practice.**

We are proud of the care that our providers give to our members. Treatment planning is individualized at the clinician and patient level. Clinicians make the determination of best practices and medical necessity for modality of care, type of intervention, goals, and frequency of return follow-up. These aspects of treatment planning and member-patient satisfaction are monitored through routinely measured Feedback Informed Care as well and the robust statewide quality oversight structure addressed above.

Kaiser Permanente has an existing well-understood practice and expectation that if any provider believes any member requires more frequent appointments than they feel able to provide, or care that cannot be accommodated within our system, the providers are expected to escalate the case to their department leadership in order to discuss options. These options often include adjusting individual provider schedules to create more availability, reducing the number of new patients assigned to a particular provider in order to increase follow up availability, considering referral to an external contract provider, or some other appropriate change in treatment planning.

Our department managers and clinical supervisors are always available to advise on scheduling and other resources to support providers' treatment plans. Clinicians' schedules are designed in such a manner that for each new patient evaluated, a weekly return visit can be accessed per the clinician's judgment. In addition, weekly group modalities and medication modalities are available to augment individual therapy, if needed. Such design ensures evidence based best practices can be implemented efficiently. Clinicians have been trained in and are encouraged to use outcome measures and Feedback Informed Care to assist in assessing patient needs for ongoing treatment. If ongoing individual therapy is needed over a prolonged period for any patient, or the clinician is having difficulty implementing effective treatment for any reason, department managers assist in removing barriers and creating any needed capacity.

To further improve the treatment of our members, our Psychiatry and Addiction Medicine departments have developed and implemented innovative programs based on evidence based best practices. Some examples of these evidence based programs include (1) enhanced processes for patients and providers to review treatment plans and progress at each visit; (2) the use of Feedback Informed Care, an evidence based support tool that providers use to improve the effectiveness of care and speed of recovery procedures; and (3) a customized program that connects patients with the appropriate level of care consistent with access standards. Our internal monitoring shows these programs provide significant benefit to our members in addressing their mental health and addiction care needs.

2. Kaiser Permanente Embraces Clinician Autonomy.

Mental Health clinicians have complete autonomy to select and design appropriate treatment plans using evidence-based guidelines, including duration and frequency of treatment. If a clinician faces any barrier in implementing their chosen treatment plan, then they are counseled and supported by their respective clinical department managers, who will assist in removing the barrier, including creating capacity. Additionally, attendance at professional case conferences and regular individual meetings with direct managers for all clinicians ensures regular review of active cases and provides the requisite support needed for the delivery of evidence-based treatment models within the paradigm of Feedback Informed Care.

3. Kaiser Permanente is a Leader in Telehealth.

The NUHW Letter refers to and attaches a "58-page complaint" NUHW filed with Kaiser's California regulator, the Department of Managed Health Care ("DMHC") concerning telehealth services. NUHW's

complaint is wrong and misleading. It is a disservice to Kaiser Permanente's therapists who are providing high quality care and to all that are seeking to improve access and care for our members. NUHW's actions threaten to undermine member confidence in an innovative way to deliver accelerated assessment and treatment through a welcoming and easily accessible process.

For years, Kaiser Permanente has been on the leading edge of delivering telemedicine to our members, so that they have quicker and more convenient access to the care they need. This approach is consistent with what our members want and what innovative healthcare organizations are doing across the country. Currently, more than half of U.S. hospitals connect with members and consulting practitioners through virtual visits and other technology.

Despite the inflammatory and misleading nature of NUHW's complaint, Kaiser Permanente investigated NUHW's allegations and provided a confidential response the DMHC in June of this year. We meet regularly with the DMHC to discuss oversight of mental health services in California, including NUHW's allegations. Kaiser Permanente remains committed to providing the best possible care to its members and will continue to work to improve and innovate care in a manner that best serves its members.

4. Kaiser Permanente is Committed to Continuously Improving.

Kaiser Permanente is proud of the behavioral health services that it offers and provides its members in California. We also take pride in being a learning organization that seeks different ways to continuously improve our operations and services. The NUHW Letter repeats and recites several of its past complaints, including various findings and actions taken by the DMHC dating back to 2013. Since NUHW's initiation of its first corporate campaign in 2011, Kaiser Permanente has responded to numerous allegations. While many of NUHW's allegations have been meritless, misleading and false, over the past eight years Kaiser Permanente has recognized those points that presented opportunities to improve. Kaiser Permanente continues to critically review its operations and performance and is committed to serving our members and setting a new standard of service.

5. NUHW Self-Administered Survey.

NUHW has not provided Kaiser Permanente with any information that would allow us to understand the validity of the NUHW self-administered survey in terms of design or administration. Kaiser Permanente is unable to assess this survey in terms of question construction, how it was administered, messaging that may have accompanied its administration or how any results were interpreted. In addition, the survey was completed while in the midst of protracted contract negotiations that are yet to be resolved.

* * *

Kaiser Permanente appreciates the opportunity to engage with the American Psychological Association. We remain available to address any questions or concerns your organization may have.

Sincerely,

/s/ Patty A. Harvey
Patti A. Harvey, RN, MPH, CPHQ
Senior Vice President, Quality, Regulatory & Clinical Operation Support
Kaiser Foundation Health Plan, Inc. and Hospitals
Southern California Region

/s/ Robin Betts
Robin Betts, MBA-HM, RN, CPHQ
Vice President, Quality, Clinical Effectiveness & Regulatory Services
Kaiser Foundation Health Plan, Inc. and Hospitals
Northern California Region

cc: Gracelyn McDermott
Executive Director, Account Management
Kaiser Permanente Mid-Atlantic States

Mark R. Ruszczyk
Vice President, Marketing, Sales & Business Development
Kaiser Permanente Mid-Atlantic States

EXHIBIT F

Patient care issues in Ventura

1 message

Greg Tegenkamp <gtegenkamp@nuhw.org> Tue, Apr 10, 2018 at 4:13 PM
To: Paul Castaldo <Paul.C.Castaldo@kp.org>
Cc: Kent Coleman <drkdangerfield@yahoo.com>

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

Thanks,

Greg Tegenkamp
NUHW Kaiser Division Director
gtegenkamp@nuhw.org

3 attachments

DMHC-Follow-UpSurveyResults_2-24-15-1.pdf
811K

KP_SoCal-LetterToClinicians2-23-15.pdf
346K

Coleman-E-mailVenturaMOB_02-26-2018.pdf
65K

June 17, 2021

Mary Watanabe, Director
Sarah Ream, General Counsel
Dan Southard, Deputy Director—Office of Plan Monitoring
Jennifer E. Marsh, Attorney III—Office of Enforcement
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER PERMANENTE BEHAVIORAL HEALTH SERVICES

Dear Ms. Watanabe, Ms. Ream, Mr. Southard, Ms. Marsh and Mr. Willis:

On behalf of the National Union of Healthcare Workers ("NUHW"), I am writing to request that the Department of Managed Health Care (DMHC) investigate Kaiser Foundation Health Plan's ("Kaiser" or "Plan") apparent violations of the California Mental Health Parity Act and other statutes and regulations that govern its provision of behavioral health services. We request an urgent investigation of Kaiser's practices, which appear to be affecting the Plan's entire Southern California region. The practices are contributing to extremely lengthy treatment delays for Kaiser's enrollees with mental health disorders, which put enrollees' health and safety at risk.

I. Summary

This complaint alleges that Kaiser is violating the California Mental Health Parity Act, California Code of Regulations Section 1300.67.2.2(c)(5)(H), and multiple other laws and regulations governing the provision of behavioral health services by California health plans. Specifically, across Kaiser's entire Southern California region, the Plan employs at least three practices that work in tandem to violate California laws.

First, Kaiser's approximately 50 behavioral health clinics across Southern California employ an appointment-scheduling rule that prohibits most enrollees from booking more than two successive individual outpatient treatment appointments with their treating non-physician licensed behavioral health clinicians ("therapist" or "therapists") regardless of enrollees' diagnoses, acuity levels or medical needs. In fact, in most of its behavioral health clinics, Kaiser prohibits enrollees from booking more than ***one*** individual mental health treatment appointment at a time. The aforementioned practice is hereinafter referred to as Kaiser's "one-appointment-at-a-time rule."

Second, Kaiser continues to employ a long-standing practice of severely understaffing both the internal network of therapists employed by its affiliated medical groups and its external network of therapists

contracted through behavioral health specialty insurers and directly as independent providers. Consequently, each of the therapists practicing in Kaiser's internal provider network typically is required to treat and manage a massive caseload of patients, the size of which Kaiser refuses to disclose to these therapists. At any given time, the schedules of Kaiser's internal therapists are generally booked completely for the ensuing 4-7 weeks.

Third, Kaiser employs an internal rule that prohibits therapists from converting future unfilled diagnostic "intake appointment" slots in their schedules into "return appointments" for the treatment of enrollees whose conditions require a treatment appointment sooner than is available in therapists' over-booked schedules. By way of background, Kaiser's managers typically place at least 6 to 8 unfilled "intake" appointment slots in each therapist's weekly schedule. Schedulers subsequently place enrollees into those unfilled slots. Kaiser refuses to allow patients or therapists to convert any unfilled intake appointment slots into "return appointments" for enrollees whose care requires them. Along with the two preceding practices, this rule has the effect of arbitrarily limiting the availability of outpatient behavioral health treatment for Kaiser's enrollees and improperly limiting the clinical autonomy of therapists to design and deliver appropriate treatment for patients under their responsibility. This practice is hereinafter referred to as Kaiser's "ban-on-converting-unfilled-intake-appointments rule."

The three practices work together in the following fashion. Under Kaiser's "one-appointment-at-a-time" rule, enrollees can only book a follow-up appointment once they have completed an appointment with their treating therapist. When an enrollee or therapist attempts to book the follow-up appointment, however, therapists' schedules are generally already completely booked for the ensuing 4-7 weeks due to Kaiser's inadequate provider network. Thus, enrollees are required to wait 4-7 weeks for their next follow-up treatment appointment. Meanwhile, Kaiser prohibits therapists from using future unfilled "intake appointments" in their schedules to deliver timely and appropriate follow-up treatment to existing patients. As a result, many thousands of Kaiser's enrollees are not receiving care consistent with their medical needs and professionally recognized standards of care.

Consider the experience of a Kaiser enrollee diagnosed with depression. The American Psychological Association (APA), which is the premier standard-setting organization for psychological care in the United States, publishes clinical practice guidelines that recommend ***weekly*** individual treatment appointments for each of seven modalities recommended for the treatment of depression.[1] Due to Kaiser's practices, however, a Kaiser enrollee in Southern California receives individual treatment appointments only once every 4-7 weeks, even at the onset of treatment. Delayed treatment can have severe impacts on patients' health and safety, including increased morbidity and mortality, delayed recovery rates, increased absences from work, job loss, and adverse impacts on family relationships. The APA and the California Psychological Association (CPA) have expressed directly to the DMHC their concerns about treatment delays at Kaiser, which were reported by APA members who practice at Kaiser's clinics in California. In a letter to the DMHC dated January 27, 2020, the APA and the California Psychological Association shared…

[1] See the APA's Clinical Practice Guidelines for Depression Treatments for Adults at https://www.apa.org/depression-guideline/adults

> "…very serious allegations from our members about extreme wait times for follow-up psychotherapy appointments for Kaiser Permanente of California subscribers. Our concern is not only that Kaiser's practices violate California law, but also that Kaiser patients risk being harmed by Kaiser falling far below professional standards of care.
>
> "We ask you to consider these allegations and to take action to correct the disturbing deficiencies in care, which we have been unable to remedy through informal talks with Kaiser… APA Services staff have been involved in access to psychological care issues for two decades. We have never seen such an egregious case of delayed access for follow-up appointments."

The APA's and CPA's joint letter is attached as Exhibit 1.

According to therapists practicing in Kaiser's internal network, Kaiser's illegal rationing of care for enrollees with MH/SUDs is systematic, widespread, and pervasive. In a recent survey performed by NUHW, 80% of these therapists reported that their clinic departments are understaffed, with not enough staff available to provide appropriate and timely care to enrollees. Eighty-seven percent reported that weekly individual psychotherapy appointments are unavailable to enrollees who need them. A summary of the survey results is available in Exhibit 2.

Kaiser's practices appear to violate multiple laws and regulations specified below. For example, Kaiser's practices place de facto quantitative treatment limitations on most enrollees' access to outpatient treatment appointments for MH/SUDs that are far more restrictive than those imposed on the outpatient treatment of medical or surgical conditions. Kaiser's practices effectively limit most enrollees to receiving 6-12 outpatient individual mental health appointments per year. Furthermore, Kaiser reportedly applies its "one-appointment-at-a-time rule" in a discriminatory fashion that targets enrollees with MH/SUDs. For example, Kaiser does not force oncology patients to book only one future chemotherapy appointment at a time, nor does it place such restrictions on enrollees receiving physical therapy. Instead, these patients are permitted to schedule a series of treatment appointments in advance. Why, then, does Kaiser impose its arbitrary appointment-scheduling restrictions on enrollees with depression, PTSD, bipolar disorder, schizophrenia, schizoaffective disorder, and other diagnoses? Why does Kaiser severely and systematically understaff its behavioral health services while adequately staffing its medical and surgical services?

NUHW has formally complained to multiple Kaiser officials about these practices, including the administrators of particular Kaiser clinics as well as the executives responsible for administering Kaiser's behavioral health services across Southern California. In our correspondence, NUHW informed Kaiser that its practices appear to represent severe violations of its enrollees' rights and California law. Nonetheless, Kaiser has refused to correct its practices. Correspondence that documents our efforts, as well as Kaiser's acknowledgement of its "one-appointment-at-a-time rule," is attached as evidence and discussed below. In addition, Kaiser's clinicians have made multiple requests to Dr. Cynthia Telles to discuss these and related problems affecting Kaiser's enrollees. Dr. Telles is a clinical psychologist at UCLA who is the only mental health professional on Kaiser Foundation Health Plan's Board of Directors.

Regrettably, she has repeatedly refused to meet with her clinical colleagues practicing at Kaiser's behavioral health facilities across California.

We request that DMHC investigate Kaiser's apparent violations and secure appropriate relief for Kaiser's enrollees—including by imposing impose fines, penalties, sanctions, and premium refunds on the Plan—if it determines that Kaiser has breached its responsibilities. A more detailed set of requests are included below in Section IV ("Requests").

II. Evidence and Discussion

The following is a brief chronology of NUHW's recent efforts to engage Kaiser to resolve these problems as well Kaiser's acknowledgment that its "one-appointment-at-a-time rule" is a deliberate practice of Kaiser. The Plan has made similar acknowledgements about its "ban-on-converting-unfilled-intake-appointments rule."

January-February 2021: Therapists practicing at Kaiser's West Los Angeles behavioral health clinics expressed verbally their objections to Kaiser's "one-appointment-at-a-time rule" to Kaiser's clinic-level managers both individually and via Kaiser's Local Professional Practice Committee. The managers refused to alter the practices.

March 2, 2021: Greg Tegenkamp, Director of NUHW's Kaiser Division, sent an email (see Exhibit 3 for email chain) to Christine M. Jordan, Southern California Permanente Medical Group's (SCPMG) Regional Assistant Medical Group Administrator for Psychiatry, Addiction Medicine and Social Medicine. The email was copied to Jeremy Lyon, Senior Labor Relations Representative for Kaiser's Southern California Region. Mr. Tegenkamp's email states in part:

> Dear Christine,
>
> I'm writing to ask for your help in addressing a DMHC/patient-care issue that's reportedly affecting patients across most, if not all, of the Southern California region. Clinicians have attempted to resolve the issue at a local level without success.
>
> Here's the problem: Many clinics have a policy that prohibits their patients and staff from scheduling more than one or two individual behavioral health appointments at a time for a given patient. Due to therapists' massive caseloads and over-booked schedules, therapists' individual return treatment appointment slots are often completely booked for 4-5 weeks into the future. In fact, therapists at several clinics report that their first available return treatment appointments are, on average, 6-7 weeks away.
>
> Given these circumstances, Kaiser's one-appointment-at-a-time rule effectively forces many patients to wait approximately 4-7 weeks between each successive individual treatment appointment. Such waits violate professionally recognized clinical standards and leave many patients without the care that's appropriate to treat their illness…

> Our concerns regarding Kaiser's one-appointment-at-a-time rule include the following: (1) this is bad patient care and places patients' health and safety at risk, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, (3) this policy appears to violate California's Mental Health Parity Act, (4) this policy appears to violate Kaiser leaders' own statements about appointment-scheduling standards and (5) this policy places NUHW members' professional licenses at risk.
>
> NUHW and the DMHC have repeatedly raised this issue to Kaiser's attention…
>
> As I mentioned, NUHW members have attempted to resolve this issue at the local level without success. Can you help us address this issue? What are your thoughts on next steps?

Ms. Jordan did not respond for more than one month and only after two follow-up emails from Mr. Tegenkamp. On April 8, Ms. Jordan responded (Exhibit 3) by stating that the "one-appointment-at-a-time rule" is a deliberate practice of Kaiser that is designed to maximize Kaiser's efficiency. Her email states in part:

> Therefore, the current practice for booking follow up appts helps us ensure appointment slots are effectively utilized and reduces the number of no-shows so fewer appointments are lost.
>
> If ever a member needs a sooner appointment than what is available, this request can be escalated to the manager who will address this in the schedule. Similarly, if there is cause for a member to need several appointments booked out into the future, this can also be escalated to a manager for resolution.
>
> Our mission is to care for our members mental health needs and we will continue striving to improve services and offerings to meet our members needs.

On April 9, Mr. Tegenkamp sent an email to Ms. Jordan (Exhibit 3) stating the following:

> Your response is not satisfactory. What you suggest sets up unnecessary barriers for patients to receive the care they need as determined by the clinical judgment of the provider. The Employer's policy appears to violate parity legislation and will likely result in a complaint being filed with the DMHC. Please feel free to call me if you wish to discuss further.

Ms. Jordan's justification of Kaiser's three practices merits discussion. She asserts that enrollees or their therapists can remedy excessive appointment wait times by escalating the problem to managers. First, it is illegal for Kaiser to design its care-delivery system to deliver, as a default outcome, a system of substandard and noncompliant care that only can be remedied if and when enrollees or their therapists

complain to Kaiser's managers. Instead, California law is abundantly clear that Kaiser must design its care-delivery system to deliver a default outcome of timely and appropriate care guided by licensed professionals and consistent with professionally recognized standards of care. The following are some of the provisions of California's laws and regulations that specify such requirements:

- "All services shall be readily available at reasonable times to each enrollee consistent with good professional practice." (California Health and Safety Code Section 1367(e)(1))

- HMOs must provide "covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice." (CCR 1300.67.2.2(c)(1)(c))

- "[P]eriodic follow-up care, including but not limited to... periodic office visits to monitor and treat... mental health conditions... **may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice**." (CCR § 1300.67.2.2(c)(5)(H)) (emphasis added)

- "Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to **prior authorization processes**, are completed in a manner that assures the provision of covered health care services to enrollees **in a timely manner appropriate for the enrollee's condition** and in compliance with the requirements of this section." (CCR § 1300.67.2.2(c)(2)) (emphasis added)

- "The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, **unhindered by fiscal and administrative management**." (California Health and Safety Code Section 1367(g)) (emphasis added)

Second, from a practical standpoint, Ms. Jordan's suggested remedy (i.e., enrollees or therapists must appeal each time a "member needs a sooner appointment than what is available") is both unworkable and unethical. The MH/SUDs for which many enrollees are seeking care often impair their capacity to traverse a series of bureaucratic hoops and hurdles in order simply to receive the care to which they are entitled. Furthermore, the management structure of Kaiser's behavioral health services is notoriously understaffed, unresponsive, and hamstrung by bureaucratic obstacles. Witness the one month it took Ms. Jordan to respond to Mr. Tegenkamp's email, even though his email contained reports of illegal practices affecting thousands of Kaiser's enrollees.

As far as therapists' capacity to successfully appeal each case of delayed treatment, they face numerous obstacles. First, delayed treatment appointments are endemic in Kaiser's behavioral health services. As reported above, in a recent survey, 80% of Kaiser's therapists reported that their clinic departments are understaffed with not enough staff available to provide appropriate and timely care to enrollees. Eighty-seven percent reported that weekly individual psychotherapy appointments are unavailable to enrollees who need them. For a therapist to appeal each of hundreds of cases of delayed care in their caseloads is

unworkable. Furthermore, Kaiser's managers typically deny therapists' appeals or only offer solutions that are unworkable. Some managers resort to bullying therapists who make such appeals.

The top executives at Kaiser, SCPMG, and The Permanente Medical Group (TPMG, which is Kaiser's affiliated medical group for Northern California) have made multiple public claims that Kaiser's systems are flexible and can easily resolve problems associated with excessive appointment wait times. The next section of this complaint ("Background") cites two such claims. One, made in writing by Kaiser's Robin Betts (Vice President of Quality, Clinical Effectiveness & Regulatory Services, KFHP) and Patti Harvey (Senior Vice President of Quality, Regulatory & Clinical Operation Support, KFHP), claims that Kaiser's "clinicians have complete autonomy to select and design appropriate treatment plans using evidence-based guidelines, including duration and frequency of treatment. If a clinician faces any barrier in implementing their chosen treatment plant, then they are counseled and supported by their respective clinical department managers, who will assist in removing the barrier, including creating capacity."

Ms. Betts' and Ms. Harvey's description of Kaiser's systems and practices is radically inconsistent with the day-to-day experiences of thousands of enrollees and therapists. It is so detached from reality that it appears to be intentionally deceptive.

III. Background

Previous investigatory findings by DMHC, complaints filed by NUHW, and other information provide important context for this complaint, which is presented below in chronological order:

March and June of 2013: DMHC published the results of its survey of Kaiser's behavioral health services, citing the Plan for multiple violations of California law including "systematic access deficiencies" that deprived thousands of Kaiser's enrollees of timely access to behavioral health services. Due to the severity of Kaiser's violations, DMHC imposed a $4 million fine on the Plan. Kaiser's violations included misinforming enrollees about their rights to obtain MH/SUD services in a fashion that discouraged enrollees from seeking care that Kaiser was legally obligated to provide. This regulatory history is important given that Kaiser's current practices similarly apply arbitrary administrative rules that prevent and discourage enrollees from obtaining the MH/SUDs care to which they are entitled.

February 13, 2015: DMHC published the results of its follow-up survey of Kaiser's behavioral health services. DMHC investigators documented enrollees' difficulty in obtaining appropriate follow-up treatment appointments after analyzing a random sample of nearly 300 medical charts from multiple service areas. Surveyors noted that "...the documentation in treatment notes suggests limited appointment availability and difficulty in obtaining follow-up appointments." (p. 24) The survey cited a provision of California law (CCR 1300.67.2.2(c)(5)(H)) that directly prohibits Kaiser from employing a "one-appointment-at-a-time rule." This provision states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." [2] In addition to violating this

[2] See for example p. 18 (Footnote 24), p. 19, p. 20 and p. 23 of DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015.

provision, DMHC cited Kaiser for misinforming its enrollees about their right to obtain mental health treatment. Surveyors noted that "... messages conveyed to enrollees in certain cases indicated that access to behavioral health services is quite limited in scope. Information... can actively discourage patients from obtaining care." (p. 30) "In addition, some materials improperly stated that long-term individual therapy was not available to enrollees." (p. 29)

February 23, 2015: In response to the deficiencies for which Kaiser was cited by DMHC in its February 2015 follow-up survey, Dr. Ed Ellison (then-CEO of the Southern California Permanente Medical Group) and Dr. Ben Chu (then-President of the Southern California Region of Kaiser Foundation Health Plan) sent a joint letter to all of Kaiser's therapists in Southern California stating in part the following. A copy is contained in Exhibit 4.

> "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

At the same time, a letter with identical language was sent to Kaiser's Northern California therapists by Dr. Don Dyson (Associate Executive Director of The Permanente Medical Group) and Barbara Crawford (Vice President for Quality and Regulatory Services, Kaiser Foundation Health Plan).

November 2, 2018: NUHW filed a complaint with DMHC regarding Kaiser's "one-appointment-at-a-time rule" and its harmful impact on Kaiser's enrollees in Ventura County. (Exhibit 5) The complaint contains correspondence documenting Kaiser's practices, NUHW's unsuccessful efforts to have Kaiser's executives remedy the problem with officials including Paul Costaldo (SCPMG's Behavioral Health Care Leader), and a therapist's email to Kaiser managers describing the impact of Kaiser's practices on a patient under his care. The therapist wrote the following email to Anna Garcia, Director of Behavioral Health at Kaiser Woodland Hills Medical Center:

> I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments "on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.

September 16, 2019: Kaiser's Robin Betts (Vice President of Quality, Clinical Effectiveness & Regulatory Services, KFHP) and Patti Harvey (Senior Vice President of Quality, Regulatory & Clinical Operation Support, KFHP) sent a six-page letter to the American Psychological Association asserting that Kaiser's "clinicians have complete autonomy to select and design appropriate treatment plans using evidence-based guidelines, including duration and frequency of treatment. If a clinician faces any barrier in implementing their chosen treatment plant, then they are counseled and supported by their respective clinical department managers, who will assist in removing the barrier, including creating capacity." (p. 4) The letter continues: "Treatment planning is individualized at the clinician and patient level. Clinicians make the determination of best practices and medical necessity for modality of care, type of intervention, roles, and frequency of return follow-up." (p. 3) "If ongoing individual therapy is needed over a prolonged period for any patient, or the clinician is having difficulty implementing effective treatment for any reason, department managers assist in removing barriers and creating any needed capacity." (p. 4) The Kaiser officials sent their letter after APA officials expressed concerns about excessive return treatment appointment delays as expressed by members of the APA who practice at Kaiser. (Exhibit 6)

October 21, 2019: NUHW filed a complaint with DMHC regarding Kaiser's "one-appointment-at-a-time" and its "ban-on-converting-intake-appointments" rules in Kaiser's behavioral health clinics serving Kern County. The complaint provided evidence, including correspondence by Kaiser managers acknowledging these practices. For example, the complaint contained an email from Robyn Field, Department Administrator of Behavioral Health Services at Kaiser's Bakersfield Behavioral Health Clinic. In her email, Ms. Field states the following (emphasis in original. See the exhibits to the October 21, 2019 complaint to view the email.):

> Please refrain from converting intakes to returns and booking more than 2 appointments at a time. Thank you for taking care of our patients!!

January 2021: In January 2021, NUHW sent a 13-minute video to Kaiser's top officers containing self-recorded reports from Kaiser therapists across the state describing the impact of understaffing and excessive appointment waits on their patients. One therapist, Brenda Melgoza from San Bernadino, reports: "I have patients that are severely, severely high risk. I've had teenagers that have attempted suicide 30 times. And yet, I don't have any availability in my schedule to see them." In the video, therapists ask Kaiser's executives—CEO Greg Adams, COO of Care Delivery Janet Liang, TPMG CEO Dr. Richard Isaacs and SCPMG Executive Medical Director Dr. Ramin Davidoff—to address the urgent problems affecting their patients. The video was also sent to Kaiser's Board of Directors, including Dr. Cynthia Telles. Regrettably, Kaiser has failed to take any apparent substantive steps to address the severe problems, which have grown worse since January.

IV. Kaiser's Apparent Legal Violations

Kaiser's practices appear to violate multiple laws and regulations enforced by the DMHC, including California's Mental Health Parity Act (as amended by SB 855) as well as other statutes and regulations including, but not limited to, the following ones regarding Network Adequacy, Clinical Appropriateness, Timely Access, Continuity of Care, Quality Assurance, and Geographic Accessibility Standards:

California Health and Safety Code (HSC) Section 1367(e)(1) "All services shall be readily available at reasonable times to each enrollee consistent with good professional practice."

HSC Section 1367(g) "The plan shall have the organizational and administrative capacity to provide services to subscribers and enrollees. The plan shall be able to demonstrate to the department that medical decisions are rendered by qualified medical providers, unhindered by fiscal and administrative management."

HSC Section 1342(d) "The plan shall furnish services in a manner providing continuity of care and ready referral of patients to other providers at times as may be appropriate consistent with good professional practice."

Title 28 California Code of Regulations (CCR) Rules 1300.67.2(d) and (f) "Within each service area of a plan, basic health care services and specialized health care services shall be readily available and accessible to each of the plan's enrollees;

> (d) The ratio of enrollees to staff, including health professionals, administrative and other supporting staff, directly or through referrals, shall be such as to reasonably assure that all services offered by the plan will be accessible to enrollees on an appropriate basis without delays detrimental to the health of the enrollees.
>
> (f) Each health care service plan shall have a documented system for monitoring and evaluating accessibility of care, including a system for addressing problems that develop, which shall include, but is not limited to, waiting time and appointments;"

Title 28 CCR Rule 1300.67.2.2(c)(1) "Plans shall provide or arrange for the provision of covered health care services in a timely manner appropriate for the nature of the enrollee's condition consistent with good professional practice. Plans shall establish and maintain provider networks, policies, procedures and quality assurance monitoring systems and processes sufficient to ensure compliance with this clinical appropriateness standard."

Title 28 CCR Rule 1300.67.2.2(c)(2) "Plans shall ensure that all plan and provider processes necessary to obtain covered health care services, including but not limited to prior authorization processes, are completed in a manner that assures the provision of covered health care services to enrollees in a timely manner appropriate for the enrollee's condition and in compliance with the requirements of this section."

Title 28 CCR Rule 1300.67.2.2(c)(5)(H) "…periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with

professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice."

Title 28 CCR Rule 1300.67.2.2(d) and (d)(3) “Quality Assurance Processes. Each plan shall have written quality assurance systems, policies and procedures designed to ensure that the plan's provider network is sufficient to provide accessibility, availability and continuity of covered health care services as required by the Act and this section.

> “(3) A plan shall implement prompt investigation and corrective action when compliance monitoring discloses that the plan's provider network is not sufficient to ensure timely access as required by this section, including but not limited to taking all necessary and appropriate action to identify the cause(s) underlying identified timely access deficiencies and to bring its network into compliance.”

Title 28 CCR Rule 1300.67.1(d) Continuity of Care “Within each service area of a plan, basic health care services shall be provided in a manner which provides continuity of care, including but not limited to… The maintenance of staff, including health professionals, administrative and other supporting staff, directly or through an adequate referral system, sufficient to assure that health care services will be provided on a timely and appropriate basis to enrollees.”

Title 28 CCR Rule 1300.70(a)(1) “The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.”

Title 28 CCR Rule 1300.70(a)(3) “A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also monitor whether the provision and utilization of services meets professionally recognized standards of practice.”

Title 28 CCR Rules 1300.70(b)(1)(A), (B) and (D) “To meet the requirements of the Act which require plans to continuously review the quality of care provided, each plan's quality assurance program shall be designed to ensure that:

- (A) a level of care which meets professionally recognized standards of practice is being delivered to all enrollees;
- (B) quality of care problems are identified and corrected for all provider entities;
- (D) appropriate care which is consistent with professionally recognized standards of practice is not withheld or delayed for any reason, including a potential financial gain and/or incentive to the plan providers, and/or others.”

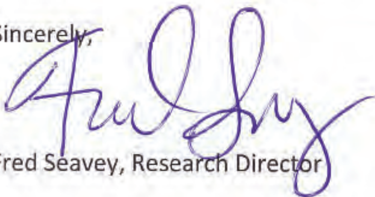
Title 28 CCR Rules 1300.70(b)(2)(G) and (G)(3) “Medical groups or other provider entities may have active quality assurance programs which the plan may use. In all instances, however, the plan must retain responsibility for reviewing the overall quality of care delivered to plan enrollees. If QA activities are delegated to a participating provider to ensure that each provider has the capability to perform effective quality assurance activities, the plan must do the following:

(3) Have ongoing oversight procedures in place to ensure that providers are fulfilling all delegated QA responsibilities."

V. Requests

NUHW requests that DMHC employ its full statutory authority to investigate Kaiser's apparent violations of state law and that it secure appropriate relief for Kaiser's enrollees and impose fines, penalties, and sanctions on the Plan if it determines that Kaiser has breached its responsibilities. We request that the DMHC order Kaiser to reimburse the monthly premiums of enrollees who were subject to any illegal practices, such as arbitrary limits on their ability to schedule appropriate treatment appointments, for the time period during which the enrollee was affected. Furthermore, we request that DMHC apply special penalties given that Kaiser, as documented below, has knowingly and intentionally engaged in a persistent and continuous pattern of practice in violation of California laws and regulations. We that DMHC make its findings known to the public. In two earlier complaints submitted to DMHC in 2018 and 2019, NUHW documented Kaiser's apparently illegal practices that are the subject of this complaint. NUHW never received any communication from DMHC regarding its findings. Finally, we request that DMHC immediately conduct a focused behavioral health investigation of Kaiser's behavioral health service and that it consult appropriately with Kaiser's therapists during the investigation. NUHW stands ready to assist in whatever ways may be helpful.

Sincerely,



Fred Seavey, Research Director

cc: Sen. Scott Wiener, Chair, Senate Mental Health Caucus
Assemblyperson Jim Wood, Chair, Assembly Health Committee
Sen. Richard Pan, Chair, Senate Health Committee
Ana Matasantos, Cabinet Secretary, Newsom Administration
Donald Moulds, Chief Health Director, CalPERS
Julie Snyder, Steinberg Institute
David Lloyd, Kennedy Forum
Alan Nessman, Esq., American Psychological Association
Jo Linder-Crow and Elizabeth Winkelman, California Psychological Association
Nabil El-Ghoroury, California Association of Marriage and Family Therapists
Deborah Son, National Association of Social Workers, California Chapter
Meiram Bendat, Esq., Psych Appeal
Board of Directors, Kaiser Foundation Health Plan

EXHIBIT 1

January 27, 2020

VIA EMAIL

Ms. Shelley Rouillard
Director, California Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

Re: Kaiser Access to Mental Health Care

Dear Director Rouillard:

The American Psychological Association (APA), American Psychological Association Services, Inc. (APA Services), and the California Psychological Association (CPA)[1] would like to offer evidence and expertise in connection with very serious allegations from our members about extreme wait times for follow-up psychotherapy appointments for Kaiser Permanente of California (Kaiser) subscribers. Our concern is not only that Kaiser's practices violate California law, but also that Kaiser patients risk being harmed by Kaiser falling far below professional standards of care.

We ask you to consider these serious allegations and to take action to correct the disturbing deficiencies in care, which we have been unable to remedy through informal talks with Kaiser. We plan to participate in the January 31st meeting scheduled by the Department of Managed Health Care (DMHC) and hope to have additional opportunities to contribute to your consideration of this matter.

---

[1] APA is the leading scientific and professional organization representing psychology in the United States, with more than 121,000 researchers, educators, clinicians, consultants and students as its members. APA Services is a legally separate companion organization to APA and supports advocacy and psychologists' economic and marketplace interests in ways that APA cannot. CPA is a 501(c)(6) non-profit professional association for licensed psychologists and others affiliated with the delivery of psychological services. CPA supports its members' professional interests, promotes and protects the science and practice of psychology, and advocates for the health and welfare of all Californians CPA represents the interests of approximately 17,000 psychologists licensed in California.

Summary of Core Allegation

In a letter to APA dated June 3, 2019 (attached) many members who work for Kaiser reported:

> Due to chronic understaffing at Kaiser's behavioral health services, our adult and child/adolescent patients—even those with complex and acute conditions such as Major Depressive Disorder-Chronic, Bipolar Disorder, Complex Post-Traumatic Stress Disorder, Eating Disorders—routinely wait 4-8 weeks between individual outpatient psychotherapy appointments with their non-physician licensed mental health clinician. At some Kaiser clinics, patients must wait as many as three to four months between appointments.

Our members believe that the company is so focused on meeting the specific time frames required under California law for *initial* appointments, e.g., 10 business days for non-urgent appointments with mental health care providers,[2] that it minimizes the importance of follow-up access. The latter is subject to less specific and non-quantitative regulatory standards – i.e. access to follow-up care must be provided consistent with "professionally recognized standards of practice" and "good professional practice."[3]

Our members also claim that Kaiser manipulates records and data on initial and follow-up care so that the company appears more compliant with applicable laws and regulations than it actually is. More disturbing are the allegations that the company intimidates or retaliates against psychologists who won't cooperate with its data manipulations, or who have raised follow-up access concerns internally and to outside entities like DMHC (including a psychologist who planned to be DMHC's witness in an administrative hearing against Kaiser).

Below is a brief overview of our relevant expertise that we would like to share with DMHC:

A. Clinical Expertise:

Follow-up Appointments: APA is the leading national authority on psychological care. In case DMHC would benefit from our input regarding "professionally recognized standards of practice" and "good professional practice" with respect to access to care, APA's position is that follow-up therapy appointments at 4-8 week or longer intervals, as alleged by our members, fall far below what is appropriate care for most patients. Psychotherapy efficacy and comparative effectiveness studies are typically based on once a week therapy (see, e.g., APA's Clinical Practice Guidelines for the Treatment of Depression and for the Treatment of Posttraumatic Stress Disorder).[4]

---

[2] 28 CCR §1300.67.2.2(c)(5)(E)
[3] Health & Safety Code §1367(d); 28 CCR § 1300.70(b)(1)(A); 28 CCR §1300.67.2.2(c)(1)
[4] https://www.apa.org/depression-guideline/index,; https://www.apa.org/ptsd-guideline/index

Initial Assessments: While we have focused on our members' core allegation about access to follow-up care, we have also reviewed the National Union of Healthcare Workers' (NUHW) complaint to DMHC dated May 14, 2019 (attached) alleging that Kaiser "games" the requirement for initial assessments under 28 CCR §1300.67.2.2(c)(5)(E) by giving patients "short-cut" half-hour (or briefer) initial phone assessments.

Our position is that these short-cut assessments are inconsistent with professionally recognized standards of care for mental health evaluations. In practice, assessment interviews are generally done in person, last a minimum of 45 to 60 minutes, cover a wide range of psychosocial and health issues, and determine an initial diagnosis and treatment plan. According to the Centers for Medicare and Medicaid Services, a psychiatric diagnostic evaluation (CPT codes 90791-90792) includes the following: a complete medical and psychiatric history; a mental status examination; establishment of an initial diagnosis; evaluation of the patient's capacity to respond to treatment; and an initial treatment plan.[5] For a comprehensive guideline, please see the American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults.[6] For a guideline on standards of care in the delivery of telepsychology services, please see the American Psychological Association Guidelines for the Practice of Telepsychology.[7]

B. Legal and Insurance Expertise:

APA Services staff have been involved in access to psychological care issues for two decades. We have never seen such an egregious case of delayed access for follow-up appointments.

We also have years of experience evaluating disparities in access to care under mental health parity laws. Kaiser's access to *medical* care seems to be very adequate, leaving the company with a dramatic disparity between good access to medical care and terrible access to mental health care. We can't see any good reason for this disparity that would save the company from a parity law violation. The only explanation that Kaiser offered us was to cite a State of California study indicating an 11% shortage of psychologists and other (non-psychiatrist) mental health providers, but the study actually referred to a projected shortage *a decade from now*.[8] We believe that Kaiser could hire more therapists readily if it admitted that this problem exists and chose to commit some of its ample resources to fixing it.[9]

---

[5] https://downloads.cms.gov/medicare-coverage-database/lcd_attachments/31887_33/Outpatient_Psych_Fact_Sheet09.18.14.pdf
[6] https://psychiatryonline.org/doi/book/10.1176/appi.books.9780890426760
[7] https://www.apa.org/practice/guidelines/telepsychology
[8] https://futurehealthworkforce.org/wp-content/uploads/2019/03/MeetingDemandForHealthFinalReportCFHWC.pdf at 10
[9] See, e.g., https://californiahealthline.org/news/bruising-labor-battles-put-kaiser-permanentes-reputation-on-the-line/

Conclusion

Kaiser's lack of timely access to mental health care has been in the news lately, but APA Services has been investigating and evaluating our members' concerns, and consulting with CPA, for the past 6 months. APA Services initially approached Kaiser with our core concerns about access to follow-up care in an effort to resolve the issue informally and collaboratively. The company's adamant denial that it has a follow-up access problem (combined with the data manipulation and intimidation/retaliation concerns) made an informal resolution unworkable; hence we are reaching out to you.

We would like to discuss these serious allegations with DMHC (and the monitor that DMHC has assigned to Kaiser's compliance if appropriate), to share more detailed information and expertise, and to urge DMHC to take action to resolve these problems and ensure appropriate access to mental health care for Kaiser patients. We look forward to participating in the January 31st meeting and to further communication on this matter.

Thank you for your attention to our concerns.

Jared Skillings, Ph.D.
Chief of Professional Practice
American Psychological Association
American Psychological Association Services, Inc.

Alan Nessman
Senior Special Counsel
Legal and Regulatory Affairs/Practice Directorate
American Psychological Association
American Psychological Association Services, Inc.

Jo Linder-Crow, PhD
Chief Executive Officer l California Psychological Association

Attachments:

June 3, 2019 letter from Kaiser psychologists to APA (psychologists' names removed)

May 14, 2019 letter from NUHW to DMHC

EXHIBIT 2

NUHW
NATIONAL UNION OF HEALTHCARE WORKERS

January 22, 2021

Survey Results: Mental Health Therapists on the Increase in Demand for Outpatient Psychiatric Services at Kaiser Permanente Facilities in California

Survey Summary:

In November and December of 2020, the National Union of Healthcare Workers (NUHW) administered an electronic survey to NUHW members throughout California who are employed by Kaiser Permanente as therapists (Psychologists, LCSWs, LMFTs, LPCCs, among others). The survey focused on measuring the change in demand for mental health and social services during the pandemic as well as understanding the impact the pandemic is having on the delivery of behavioral health and social services, including workload issues for NUHW members. This summary encapsulates over 2,000 therapist responses from the nation's largest nonprofit HMO.

Survey Highlights:

- 92% of the respondents state that, during 2020, the acuity levels of their patients increased, with 61% reporting that acuity levels significantly increased during 2020.
- 87% of therapists report that weekly individual psychotherapy appointments are unavailable for patients who need it.
- 79% of the respondents indicate that patients' wait times for individual return appointments in their clinic have grown worse during the past 12 months with nearly 50% reporting they have increased significantly.
- 65% of respondents report that on a daily basis, they must schedule their patients' return appointments further into the future than is clinically appropriate.
- 70% of therapists state that their clinic or worksite has eliminated or curtailed therapy groups that have been helpful to patients. In addition, of the group therapy and classes that still exist, 72% report that patients are being placed on waitlists due to the inadequate availability of these services.
- 87% of the respondents state that, during 2020, their workload increased and of this total, 63% report that their workload increased significantly.
- 55% of the respondents indicate that during the past six months they've considered leaving Kaiser. In several locations, responses indicate that as many as 75% report

that they have considered leaving Kaiser in the past six months.

- 80% report that their clinic departments are understaffed with not enough staff available to provide appropriate and timely care to patients.

- 34% report an increase in the frequency of negative patient outcomes, in particular suicides or overdoses, since the start of the pandemic.

These findings indicate that Kaiser's capacity to deliver clinically appropriate care to its enrollees, already severely compromised before the pandemic, has deteriorated substantially even as enrollees' demand for mental health services has increased. Furthermore, the problems are systemic and enduring in that they are not limited to particular subregions of the state and the under-staffing of Kaiser's mental health clinics has persisted over years. Finally, the survey indicates widespread dissatisfaction among its clinician staff, with 55% reporting they have considered leaving Kaiser during the past six months.

Survey Notes:

Instrument & Methodology: The survey was distributed electronically via Qualtrics to each Kaiser therapist for whom NUHW has a valid personal email. Each therapist who received the survey obtained a unique link for completion which allowed for follow-up tracking on completions. Individual responses are confidential and responses are only reported in aggregate form.

The majority of the questions were presented in multiple choice form. Because of the regional nature in which Kaiser's services are delivered, a small portion of survey questions differed depending on a therapist's work region (Northern vs. Southern California). In addition, a subset of questions were tailored specifically to therapists who provide psychotherapy to children, adults and families in a Kaiser Psychiatry Department.

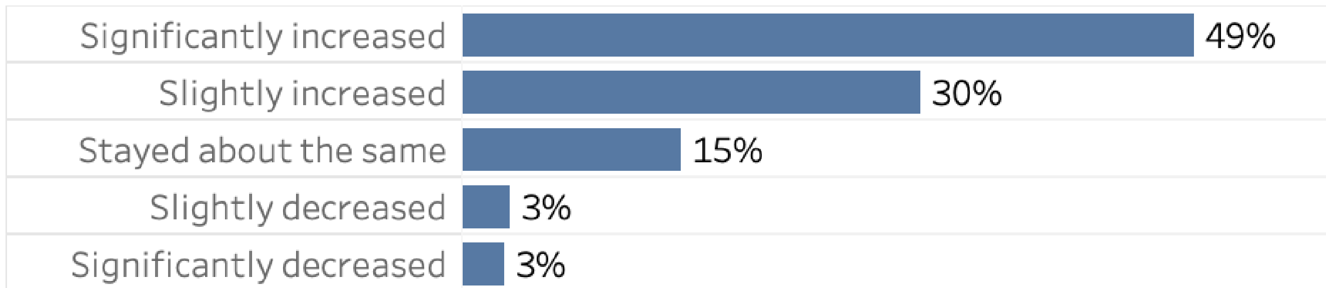
Survey Data: The survey was sent to 3,496 Kaiser clinicians. Responses were received from 2,097 mental health providers practicing across Kaiser Permanente's various facilities in Northern and Southern California.

For Southern California, a total of 901 survey responses were received out of 1,642 surveys distributed representing a 54.8% response rate.

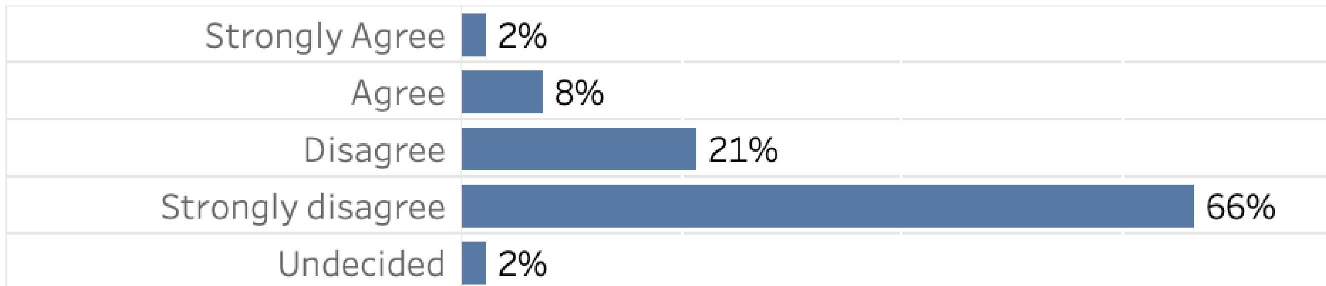
For Northern California, a total of 1,196 survey responses were received out of 1,854 surveys distributed representing a 64.5% response rate.

# # #

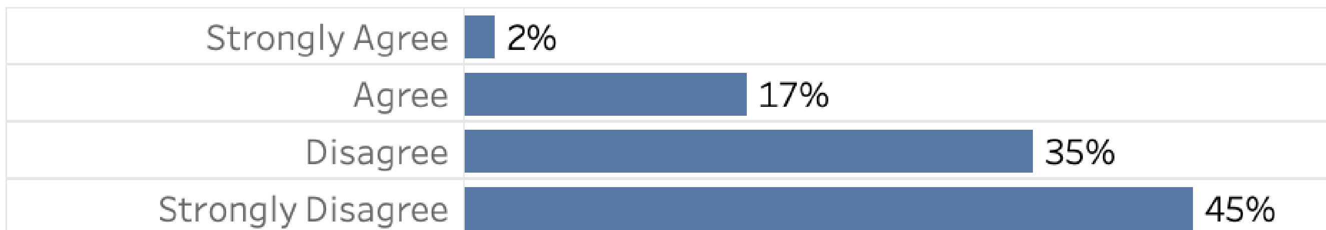
On average, to what extent have wait times for individual return appointments for your patients increased or decreased over the last 12 months?



Weekly individual psychotherapy appointments at your clinic or worksite are available to those who need it:



There are usually enough staff in my department to provide appropriate and timely care to patients.



Note: Data for above charts reflect combined response numbers from both Northern and Southern California.

EXHIBIT 3

From: Greg Tegenkamp <gtegenkamp@nuhw.org>
Subject: Re: Limits on Follow-up appointments
Date: April 9, 2021 at 12:09:10 PM PDT
To: Christine M Jordan <Christine.M.Jordan@kp.org>
Cc: Jeremy Lyon <Jeremy.X.Lyon@kp.org>, Tina S Han <Tina.S.Han@kp.org>

Christine,

Your response is not satisfactory. What you suggest sets up unnecessary barriers for patients to receive the care they need as determined by the clinical judgment of the provider. The Employer's policy appears to violate parity legislation and will likely result in a complaint being filed with the DMHC. Please feel free to call me if you wish to discuss further.

Thanks,

GREG TEGENKAMP
Kaiser Division Director
National Union of Healthcare Workers
gtegenkamp@nuhw.org
(415)640-0648

From: Christine M Jordan <Christine.M.Jordan@kp.org>
Subject: RE: Limits on Follow-up appointments
Date: April 8, 2021 at 6:27:42 PM PDT
To: "gtegenkamp (nuhw.org)" <gtegenkamp@nuhw.org>
Cc: Jeremy Lyon <Jeremy.X.Lyon@kp.org>, Tina S Han <Tina.S.Han@kp.org>

Greetings Greg,

First, I wish to thank you for your patience in awaiting my response. I have reviewed your letter of concern as well as the attachments.

To most directly answer your concern, let me begin by saying that Behavioral health schedules are created in advance to meet projected demands. The schedules include a variety of appointment slots to address a variety of visit types to include initial visits, urgent visits, follow up visits, group visits etc. Managing access at the regional level as well as the local level is a dynamic process that fluctuates daily as changes in demand and supply occur. Therefore, the current practice for booking follow up appts helps us ensure appointment slots are effectively utilized and reduces the number of no-shows so fewer appointments are lost.

If ever a member needs a sooner appointment than what is available, this request can be escalated to the manager who will address this in the schedule. Similarly, if there is cause for a member to need several appointments booked out into the future, this can also be escalated to a manager for resolution.

Our mission is to care for our members mental health needs and we will continue striving to improve services and offerings to meet our members needs.

Thank you

Christine M Jordan LCSW
SCPMG Regional AMGA
Psychiatry
Addiction Medicine
Social Medicine
393 E Walnut Street
Pasadena Ca 91188
Cell 626-298-5895

Administrative Support:
Maryam Eapen

From: Greg Tegenkamp <gtegenkamp@nuhw.org>
Sent: Tuesday, March 2, 2021 12:14 PM
To: Christine M Jordan <Christine.M.Jordan@kp.org>
Cc: Jeremy Lyon <Jeremy.X.Lyon@kp.org>
Subject: Limits on Follow-up appointments

Caution: This email came from outside Kaiser Permanente. Do not open attachments or click on links if you do not recognize the sender.

Dear Christine,

I'm writing to ask for your help in addressing a DMHC/patient-care issue that's reportedly affecting patients across most, if not all, of the Southern California region. Clinicians have attempted to resolve the issue at a local level without success.

Here's the problem: Many clinics have a policy that prohibits their patients and staff from scheduling more than one or two individual behavioral health appointments at a time for a given patient. Due to therapists' massive caseloads and over-booked schedules, therapists' individual return treatment appointment slots are often completely booked for 4-5 weeks into the future. In fact, therapists at several clinics report that their first available return treatment appointments are, on average, 6-7 weeks

away.

Given these circumstances, Kaiser's one-appointment-at-a-time rule effectively forces many patients to wait approximately 4-7 weeks between each successive individual treatment appointment. Such waits violate professionally recognized clinical standards and leave many patients without the care that's appropriate to treat their illness. For example, the American Psychological Association, which is the premier standard-setting organization for psychological care in the United States, recommends either weekly or biweekly therapy for the treatment of PTSD, depression, and obsessive-compulsive disorder. The APA's Clinical Practice Guidelines are available on the APA's website. For depression, the APA recommends seven psychotherapy interventions, all of which are recommended to be delivered to patients on a weekly basis via individual treatment appointments.

Our concerns regarding Kaiser's one-appointment-at-a-time rule include the following: (1) this is bad patient care and places patients' health and safety at risk, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, (3) this policy appears to violate California's Mental Health Parity Act, (4) this policy appears to violate Kaiser leaders' own statements about appointment-scheduling standards and (5) this policy places NUHW members' professional licenses at risk.

NUHW and the DMHC have repeatedly raised this issue to Kaiser's attention. For example, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

On February 23, 2015, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

In April of 2018, NUHW raised to the attention of Paul Castaldo, who then served as the Regional Leader for Behavioral Health Care at SCPMG, that Kaiser was continuing to carry out this practice at some of its clinics in Southern California.

With respect to our concerns regarding the California Mental Health Parity Act, we are troubled that Kaiser has established appointment-scheduling rules that are far more restrictive for patients with mental health and substance use disorders than for patients with "physical" illnesses or conditions. Patients receiving chemotherapy are not required to schedule one appointment at a time. Why then should patients with Major Depressive Disorder, a potentially fatal illness, be subjected to more restrictive rules that impede their ability to access clinically appropriate care and treatment?

As I mentioned, NUHW members have attempted to resolve this issue at the local level without success. Can you help us address this issue? What are your thoughts on next steps?

Thanks,

GREG TEGENKAMP
Kaiser Division Director
National Union of Healthcare Workers
gtegenkamp@nuhw.org
(415)640-0648

EXHIBIT 4

February 23, 2015

Re: DMHC Mental Health Follow-up Survey

Dear Behavioral Medicine Colleagues,

Thank you for all you do every day to care for our members in need of your compassion, caring and expertise. Your dedication to our patients, colleagues and the organization is greatly appreciated. We would like to update you on the Department of Managed Health Care (DMHC) Behavioral Health (BH) Follow-Up Survey. As you are aware, the DMHC surveyed our BH services in 2012-13. Their 2013 BH Final Report included findings regarding capacity, Health Plan oversight and inaccurate member communications. The DMHC then conducted a follow- up survey in 2013-14.

The DMHC Follow-Up Report will be released on Tuesday, February 24, and we want you to know the findings before they are made public. The DMHC has determined that two of the four original deficiencies are resolved and two are not. The DMHC reviewed 297 charts, citing 14 of the 149 charts for SCAL with untimely return access. They also have monitored our monthly access reports and while they noted significant progress, they state there is still inconsistency and lack of stability in access for some Medical Centers.

The DMHC also found three comments within the 297 charts that it identified as inaccurate. One provider inaccurately stated that longer-term therapy is not a covered benefit under the Health Plan and then offered to provide the member with suggestions for low-cost clinics in the community that the member might consider paying for separately. Another provider inaccurately stated that no one ever sees a therapist once a week in the Health Plan and that it was not a covered benefit. Although such statements were only identified in approximately 1 percent of the reviewed medical records, it is important that we provide accurate information to our members.

Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services.

While we are disappointed that the DMHC did not find that all deficiencies were fully corrected, we are also proud of the work you have done to improve and maintain access to Behavioral Health services. The new survey was based on 2013 results and we know that thanks to you, as well as our continued investments in mental health care, our access continued to improve in 2014.

Over the past five years, Southern California has increased staffing by 60 percent; has developed contracts to support therapy access; has enhanced our IOP programs, and taken other meaningful steps to improve our Behavioral Health care delivery. In concert with other Area leaders, we are planning for additional staff and offices for Behavioral Health. We know there is an additional solution to be found and have formed a Behavioral Health Strategy committee to guide that work.

We appreciate your continued commitment to our patients, which is critical in our intent to create the premier behavioral health care delivery model in the country.

Sincerely,

Edward Ellison, MD
Executive Medical Director
Southern California Permanente Medical Group

Benjamin K. Chu, MD, MPH
Regional President
Kaiser Permanente Southern California

EXHIBIT 5

(866) 968-NUHW (6849) ❖ NUHW.org ❖ info@nuhw.org

November 2, 2018

Shelley Rouillard, Director
Dan Southard, Deputy Director—Office of Plan Monitoring
Jennifer E. Marsh, Attorney III —Office of Enforcement
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER FOUNDATION HEALTH PLAN INC. ENFORCEMENT MATTER NOs. 11-543 & 15-082

Dear Ms. Rouillard, Mr. Southard, Ms. Marsh and Mr. Willis:

On behalf of the National Union of Healthcare Workers ("NUHW"), I am writing to provide the Department of Managed Health Care ("DMHC") with evidence of Kaiser Permanente's noncompliance with California law and the DMHC's Cease and Desist Order issued in June of 2013.

At Kaiser's behavioral health clinic in Ventura, Calif., Kaiser employs the following appointment-scheduling rule: At any given time, patients are prohibited from booking more than two successive individual treatment appointments with their non-physician licensed behavioral health provider regardless of a patient's diagnosis or acuity. In order to place a third appointment on the schedule, the patient's treating provider typically must make an individual request for each such appointment to either Anna Garcia, Director of Behavioral Health at Kaiser Woodland Hills Medical Center or, more recently, to her subordinate. Furthermore, if permission is granted, the provider is only permitted to conduct the third appointment during non-patient care periods of the provider's schedule, such as during the provider's limited case-management slots. Patients themselves are not permitted to schedule three or more successive behavioral health appointments regardless of regardless of their diagnosis or acuity.

Our concerns about this appointment-scheduling rule include, but are not limited to, the following:

1. This policy unfairly limits patients' access to Kaiser's behavioral health services. By placing unnecessary appointment-scheduling hurdles in the paths of patients and providers, it has the effect of diminishing patients' access to treatment appointments. The harmful effects of this appointment-setting rule are intensified by the limited availability of behavioral health appointments at the Ventura clinic. Many providers' schedules are completely booked for as many as two months due to the inadequacy of the clinic's provider network. Thus, by

delaying the scheduling of a patient's third appointment until a future point in time, Kaiser forces that patient to endure a lengthier wait for the third appointment than clinically indicated.

2. This policy violates a provision of California law for which Kaiser has already been cited by the DMHC. Specifically, Rule 1300.67.2.2(c)(5)(H) states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See, for example, page 23, page 18 (Footnote 24), page 19, and page 20 of the DMHC's "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services" dated February 24, 2015.
3. This policy contradicts Kaiser's instructions to behavioral health providers issued in February 2015 in conjunction with the DMHC's Follow-up Survey results. On February 23, 2015, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to physician and non-physician behavioral health providers stating, in part, the following (emphasis added): "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**." (See Exhibit I)
4. This policy appears to violate mental health parity laws. Kaiser reportedly places fewer appointment-scheduling restrictions on patients receiving medical and surgical care. For example, Kaiser reportedly does not limit oncology patients to only receive their third chemotherapy appointment during a provider's non-patient treatment hours.
5. This policy appears to violate California Code of Regulations § 1300.67.3, which requires HMOs to ensure that "medical decisions will not be unduly influenced by fiscal and administrative management."

For nearly two years, therapists at Kaiser's Ventura clinic have expressed their objections to this policy in both verbal and written form to multiple Kaiser officials including clinic-based supervisors as well as Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Paul Costaldo (Behavioral Health Care Leader for Kaiser's Southern California Region, SCPMG). Despite these requests, Kaiser has refused to reverse its policy. Kaiser reportedly employs a similar appointment-scheduling rule at other clinic sites, including the Child & Adolescent Program at Woodland Hills.

Exhibit II is an e-mail dated February 26, 2018 entitled "Restriction of Clinical Care" and authored by Dr. Kent Coleman, a Clinical Psychologist practicing at Kaiser's Ventura Medical Office Building. The e-mail is addressed to Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Demetria Mays-Flowers (Reception Supervisor). It is copied to clinical team members and others. The following is an excerpt from the e-mail. The term "case management slots" refers to periods of time in each therapist's schedule that are intended for case management, not direct patient care.[1] In the e-mail, Dr. Coleman references his

over-booked schedule, which is common among many therapists. As of February 23, 2018, the first available open slot in Dr. Coleman's appointment schedule was more than two months later (on May 1). Today, Dr. Coleman's schedule continues to be booked out for a similar amount of time.

> Good Afternoon:
>
> I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments "on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.
>
> Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)] states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner."
>
> Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care.

Exhibit III contains an e-mail dated April 10, 2018 entitled "Patient care issues in Ventura" and authored by Greg Tegenkamp, the Director of NUHW's Kaiser Division. The e-mail is addressed to Paul Costaldo (Behavioral Health Care Leader, SCPMG), who leads Kaiser's behavioral healthcare services across Kaiser's Southern California Region. Mr. Tegenkamp's e-mail includes three attachments. Mr. Costaldo responded verbally to Mr. Tegenkamp's e-mail, stating that clinic managers had a different view of the issue. The clinic's appointment scheduling rule remains unchanged and is in force to this day. Mr. Tegenkamp's e-mail reads as follows:

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

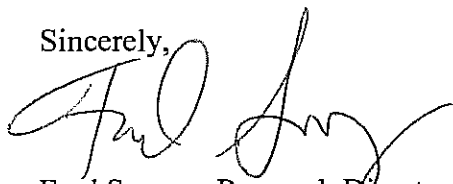
In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

NUHW requests that the DMHC investigate Kaiser's appointment-scheduling rule and its compliance with California laws and regulations. Please contact me with any questions.

Sincerely,



Fred Seavey, Research Director

---

[1] During an 8-hour workday, a therapist is scheduled to perform 6 hours of direct patient care (i.e., 75% of his/her work hours). The remaining time is designated to be used for case-management duties (1 hour) and patient management time (1 hour). During patient management time, therapists are intended to perform patient charting, make phone calls, write e-mails and letters, prepare for group classes and individual appointment, and perform other non-direct care duties associated with their clinical responsibilities.

Exhibit I

February 23, 2015

Re: DMHC Mental Health Follow-up Survey

Dear Behavioral Medicine Colleagues,

Thank you for all you do every day to care for our members in need of your compassion, caring and expertise. Your dedication to our patients, colleagues and the organization is greatly appreciated. We would like to update you on the Department of Managed Health Care (DMHC) Behavioral Health (BH) Follow-Up Survey. As you are aware, the DMHC surveyed our BH services in 2012-13. Their 2013 BH Final Report included findings regarding capacity, Health Plan oversight and inaccurate member communications. The DMHC then conducted a follow- up survey in 2013-14.

The DMHC Follow-Up Report will be released on Tuesday, February 24, and we want you to know the findings before they are made public. The DMHC has determined that two of the four original deficiencies are resolved and two are not. The DMHC reviewed 297 charts, citing 14 of the 149 charts for SCAL with untimely return access. They also have monitored our monthly access reports and while they noted significant progress, they state there is still inconsistency and lack of stability in access for some Medical Centers.

The DMHC also found three comments within the 297 charts that it identified as inaccurate. One provider inaccurately stated that longer-term therapy is not a covered benefit under the Health Plan and then offered to provide the member with suggestions for low-cost clinics in the community that the member might consider paying for separately. Another provider inaccurately stated that no one ever sees a therapist once a week in the Health Plan and that it was not a covered benefit. Although such statements were only identified in approximately 1 percent of the reviewed medical records, it is important that we provide accurate information to our members.

Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services.

While we are disappointed that the DMHC did not find that all deficiencies were fully corrected, we are also proud of the work you have done to improve and maintain access to Behavioral Health services. The new survey was based on 2013 results and we know that thanks to you, as well as our continued investments in mental health care, our access continued to improve in 2014.

Over the past five years, Southern California has increased staffing by 60 percent; has developed contracts to support therapy access; has enhanced our IOP programs, and taken other meaningful steps to improve our Behavioral Health care delivery. In concert with other Area leaders, we are planning for additional staff and offices for Behavioral Health. We know there is an additional solution to be found and have formed a Behavioral Health Strategy committee to guide that work.

We appreciate your continued commitment to our patients, which is critical in our intent to create the premier behavioral health care delivery model in the country.

Sincerely,

Edward Ellison, MD
Executive Medical Director
Southern California Permanente Medical Group

Benjamin K. Chu, MD, MPH
Regional President
Kaiser Permanente Southern California

Exhibit II

Kent L Coleman <Kent.L.Coleman@kp.org> Mon, Feb 26, 2018 at 1:06 PM
To: Demetria Mays <Demetria.M.Mays-Flowers@kp.org>
Cc: H Anna Garcia <H.Anna.Garcia@kp.org>, Fred Seavey <fseavey@nuhw.org>, "Susan K. Pembroke" <Susan.K.Pembroke@kp.org>, Lisa M Klein <Lisa.M.Klein@kp.org>, Lindsey E Mccormack <Lindsey.E.McCormack@kp.org>, "Katherine D. Cianci" <Katherine.D.Cianci@kp.org>, Cindy L Simental <Cindy.L.Simental@kp.org>, Jessica Bray <Jessica.Bray@kp.org>, Vanesa F Lay <Vanesa.F.Lay@kp.org>, Regina L Isaias <Regina.L.Isaias@kp.org>, Pamela L Chapman <Pam.X.Chapman@kp.org>, Thomas M Letvinchuck <Thomas.M.Letvinchuck@kp.org>, Ilena T Sussman <Ilena.T.Sussman@kp.org>, Sarah M Williams <Sarah.M.Williams@kp.org>, James K Borgeson <James.K.Borgeson@kp.org>, Christine L Johnson <Christine.L.Johnson@kp.org>, "Samantha W. Bookman" <Samantha.W.Bookman@kp.org>

Good Afternoon:

I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments " on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.

Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)} states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. "**

Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care. If for any reason you are unable to effect these changes, please advise. In my meetings with Paul Castaldo he has requested that we try to resolve these type of issues at the local level first. If unable, I will take this to region and DMHC.

I know you care about the patients. If there is anything I can do to facilitate this change let me know as well. Thanks.

Kent L. Coleman PhD

Licensed Clinical Psychologist

Steward/E Board NUHW

Ventura MOB

Exhibit III

Patient care issues in Ventura

1 message

Greg Tegenkamp <gtegenkamp@nuhw.org>
To: Paul Castaldo <Paul.C.Castaldo@kp.org>
Cc: Kent Coleman <drkdangerfield@yahoo.com>

Tue, Apr 10, 2018 at 4:13 PM

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

Thanks,

Greg Tegenkamp
NUHW Kaiser Division Director
gtegenkamp@nuhw.org

3 attachments

DMHC-Follow-UpSurveyResults_2-24-15-1.pdf
811K

KP_SoCal-LetterToClinicians2-23-15.pdf
346K

Coleman-E-mailVenturaMOB_02-26-2018.pdf
65K

EXHIBIT 6

September 16, 2019

SENT VIA ELECTRONIC MAIL TO: ANessman@apa.org

Alan Nessman, JD – Senior Special Counsel, Legal & Regulatory Affairs
American Psychological Association
Practice Directorate
750 First St. NE
Washington, DC 20002-4242

RE: ***June 3, 2019 Letter from National Union of Healthcare Workers/APA Members***

Dear Mr. Nessman:

Thank you for your recent inquiry prompted by the June 3, 2019 letter from certain National Union of Healthcare Workers ("NUWH") and APA members ("NUHW Letter") expressing concerns regarding Kaiser Permanente members' access to timely and appropriate mental health services in California. We appreciate the opportunity to provide a response.

We agree that every Kaiser Permanente member – and in fact every American – should have access to high-quality mental health care when they need it. This is one of the top health care priorities of our day. Kaiser Permanente is at the forefront of meeting this challenge head on and we are getting results thanks to the dedication of our mental health teams. This includes our frontline clinicians in California represented by the NUHW, which we have been in contract negotiations with for more than a year.

The NUHW Letter is part of an ongoing public pressure campaign by NUHW leadership to try and pressure Kaiser Permanente management to agree to their financial demands in bargaining. We have urged NUHW's leadership to bargain constructively and stop putting our patients in the middle of their contract demands. The NUHW Letter is a clear attempt to drag the APA into the NUHW's corporate campaign. Despite the NUHW's tactics, Kaiser Permanente remains committed to responsibly reaching a new contract agreement, which is what our therapists and patients deserve.

Below we provide an overview of Kaiser Permanente's commitment to ensuring access to timely and appropriate mental health services in our two California regions. We also respond to the unfounded allegations raised in the NUHW Letter.

Kaiser Permanente California – Mental Health Services

Kaiser Permanente Northern California is the only health plan in the state to earn 5 stars – the highest possible rating – for behavioral and mental health care access and quality according to the California Office of the Patient Advocate (OPA) 2018 Report Card. Kaiser Permanente Southern California is one of only three plans in the state to receive the Report Card's next highest possible rating.

Still, we know that all mental health care providers — including Kaiser Permanente — have work to do to improve. We have a broad range of initiatives designed to increase access, continually improve and set a new standard of service excellence. They include:

- **Improved Quality Oversight.** Kaiser Permanente is committed to timely access, and we continue to improve our performance in meeting or exceeding the established regulatory standard for first appointments for behavioral health. We actively monitor and review the quality and service levels for behavioral health services, providing feedback on gaps in performance and the need to perform to plan. This includes auditing of triage assessment documentation for initial behavioral health appointments booked beyond regulatory guidelines. We continue auditing individual provider treatment plans to ensure follow-up appointments are offered at return intervals consistent with the patient's treatment plan. When a site is out of compliance, we ensure that corrective action plans ("CAPs") document the root cause analysis and corrective action interventions. And, we continue to refine the escalation process, enhance interventions, and employ best practices to make progress with sites that are out of compliance.

- **Adding More Resources:** In its February 2019 report on the overall shortage of health professionals in California, the California Future Health Workforce Commission states that unless the state makes dramatic policy changes, "California will have 41% fewer psychiatrists and 11% fewer psychologists, marriage and family therapists, clinical counselors, and social workers than it will need." Despite the national and state shortage of trained mental health professionals, Kaiser Permanente has hired more than 1,100 new therapists and filled more than 2,600 mental health positions in California from 2016 through present, and we continue to hire more (also see "Growing the Workforce" below). Through our integrated delivery model, our members are offered and receive comprehensive mental health services in settings where they are and where they want to receive care.

- **More Treatment Locations:** We are accelerating our ongoing $700-million project to expand and enhance our mental health care treatment facilities, with the goal of making mental health care more available and improving access in environments that offer our patients convenience, comfort and privacy.

- **Embedding Mental Health Care in Primary Care:** Our primary care and mental health providers work together to make mental health and wellness part of a patient's total health. We are making it possible for members to receive mental health care throughout our organization, including embedding mental health professionals in primary care clinics and emergency departments.

- **Innovative Options:** Our use of innovative technology is growing rapidly, driven by the preferences of our patients for ease of access and convenience. On an annual basis, we provide hundreds of thousands of tele-health visits statewide, allowing patients to communicate with their therapists from the privacy and comfort of their homes.

- **Growing the Workforce:** We provide an extensive array of training opportunities statewide for more than 300 trainees each year, including residency training programs in psychiatry in Northern and Southern California, and training opportunities and assistantships for post-masters and pre- and post-doctoral level mental health providers. We are moving forward with several initiatives totaling $50 million that will increase the number of people who are entering mental health professions. This includes tuition assistance for our current employees, fellowships and residencies for future hires, and grants to expand capacity in degree programs, with an emphasis in graduating bilingual and/or diverse students who reflect community needs. We are also committing $6 million to encourage our therapists' engagement in clinical research to further develop evidence-based treatment and outcomes.

- **Designing the Future of Care:** We've proposed creating an intensive work group of therapists and management, to advance innovation and evidence-based practice in our model of care. We believe – as do our therapists – that the dramatic increase in mental health care demand cannot be fully met without changes in the way mental health services are provided. We are reimagining the continuum of mental health and addiction care to incorporate opportunities afforded by new technologies, the use of collaborative care in primary care, and by rigorously applying the evidence base of what works in specialty care. This new continuum will allow us to serve the mental health needs of our population in new and even more effective ways.

- **Reducing Stigma:** Kaiser Permanente is committed to reducing stigma associated with mental health treatment. For example, in 2016, Kaiser Permanente launched the national "Find Your Words" public health awareness campaign (findyourwords.org), joining forces with others in the field to spark a national conversation about depression. This is one of several national initiatives we have launched to help reduce the stigma that can be a personal barrier to reaching out for mental health support.

<u>Allegations in NUHW Letter</u>

The NUHW Letter alleges Kaiser Permanente has violated professionally recognized standards of practice in delivery mental health services. Each allegation is separately addressed below.

1. **Kaiser Permanente's Northern California and Southern California Behavioral Health Clinics are meeting timely access requirements in compliance with professionally recognized standards of practice.**

We are proud of the care that our providers give to our members. Treatment planning is individualized at the clinician and patient level. Clinicians make the determination of best practices and medical necessity for modality of care, type of intervention, goals, and frequency of return follow-up. These aspects of treatment planning and member-patient satisfaction are monitored through routinely measured Feedback Informed Care as well and the robust statewide quality oversight structure addressed above.

Kaiser Permanente has an existing well-understood practice and expectation that if any provider believes any member requires more frequent appointments than they feel able to provide, or care that cannot be accommodated within our system, the providers are expected to escalate the case to their department leadership in order to discuss options. These options often include adjusting individual provider schedules to create more availability, reducing the number of new patients assigned to a particular provider in order to increase follow up availability, considering referral to an external contract provider, or some other appropriate change in treatment planning.

Our department managers and clinical supervisors are always available to advise on scheduling and other resources to support providers' treatment plans. Clinicians' schedules are designed in such a manner that for each new patient evaluated, a weekly return visit can be accessed per the clinician's judgment. In addition, weekly group modalities and medication modalities are available to augment individual therapy, if needed. Such design ensures evidence based best practices can be implemented efficiently. Clinicians have been trained in and are encouraged to use outcome measures and Feedback Informed Care to assist in assessing patient needs for ongoing treatment. If ongoing individual therapy is needed over a prolonged period for any patient, or the clinician is having difficulty implementing effective treatment for any reason, department managers assist in removing barriers and creating any needed capacity.

To further improve the treatment of our members, our Psychiatry and Addiction Medicine departments have developed and implemented innovative programs based on evidence based best practices. Some examples of these evidence based programs include (1) enhanced processes for patients and providers to review treatment plans and progress at each visit; (2) the use of Feedback Informed Care, an evidence based support tool that providers use to improve the effectiveness of care and speed of recovery procedures; and (3) a customized program that connects patients with the appropriate level of care consistent with access standards. Our internal monitoring shows these programs provide significant benefit to our members in addressing their mental health and addiction care needs.

2. Kaiser Permanente Embraces Clinician Autonomy.

Mental Health clinicians have complete autonomy to select and design appropriate treatment plans using evidence-based guidelines, including duration and frequency of treatment. If a clinician faces any barrier in implementing their chosen treatment plan, then they are counseled and supported by their respective clinical department managers, who will assist in removing the barrier, including creating capacity. Additionally, attendance at professional case conferences and regular individual meetings with direct managers for all clinicians ensures regular review of active cases and provides the requisite support needed for the delivery of evidence-based treatment models within the paradigm of Feedback Informed Care.

3. Kaiser Permanente is a Leader in Telehealth.

The NUHW Letter refers to and attaches a "58-page complaint" NUHW filed with Kaiser's California regulator, the Department of Managed Health Care ("DMHC") concerning telehealth services. NUHW's

complaint is wrong and misleading. It is a disservice to Kaiser Permanente's therapists who are providing high quality care and to all that are seeking to improve access and care for our members. NUHW's actions threaten to undermine member confidence in an innovative way to deliver accelerated assessment and treatment through a welcoming and easily accessible process.

For years, Kaiser Permanente has been on the leading edge of delivering telemedicine to our members, so that they have quicker and more convenient access to the care they need. This approach is consistent with what our members want and what innovative healthcare organizations are doing across the country. Currently, more than half of U.S. hospitals connect with members and consulting practitioners through virtual visits and other technology.

Despite the inflammatory and misleading nature of NUHW's complaint, Kaiser Permanente investigated NUHW's allegations and provided a confidential response the DMHC in June of this year. We meet regularly with the DMHC to discuss oversight of mental health services in California, including NUHW's allegations. Kaiser Permanente remains committed to providing the best possible care to its members and will continue to work to improve and innovate care in a manner that best serves its members.

4. **Kaiser Permanente is Committed to Continuously Improving.**

Kaiser Permanente is proud of the behavioral health services that it offers and provides its members in California. We also take pride in being a learning organization that seeks different ways to continuously improve our operations and services. The NUHW Letter repeats and recites several of its past complaints, including various findings and actions taken by the DMHC dating back to 2013. Since NUHW's initiation of its first corporate campaign in 2011, Kaiser Permanente has responded to numerous allegations. While many of NUHW's allegations have been meritless, misleading and false, over the past eight years Kaiser Permanente has recognized those points that presented opportunities to improve. Kaiser Permanente continues to critically review its operations and performance and is committed to serving our members and setting a new standard of service.

5. **NUHW Self-Administered Survey.**

NUHW has not provided Kaiser Permanente with any information that would allow us to understand the validity of the NUHW self-administered survey in terms of design or administration. Kaiser Permanente is unable to assess this survey in terms of question construction, how it was administered, messaging that may have accompanied its administration or how any results were interpreted. In addition, the survey was completed while in the midst of protracted contract negotiations that are yet to be resolved.

* * *

Kaiser Permanente appreciates the opportunity to engage with the American Psychological Association. We remain available to address any questions or concerns your organization may have.

Sincerely,

/s/ Patty A. Harvey
Patti A. Harvey, RN, MPH, CPHQ
Senior Vice President, Quality, Regulatory & Clinical Operation Support
Kaiser Foundation Health Plan, Inc. and Hospitals
Southern California Region

/s/ Robin Betts
Robin Betts, MBA-HM, RN, CPHQ
Vice President, Quality, Clinical Effectiveness & Regulatory Services
Kaiser Foundation Health Plan, Inc. and Hospitals
Northern California Region

cc: Gracelyn McDermott
Executive Director, Account Management
Kaiser Permanente Mid-Atlantic States

Mark R. Ruszczyk
Vice President, Marketing, Sales & Business Development
Kaiser Permanente Mid-Atlantic States

EXHIBIT 7

NUHW NATIONAL UNION OF HEALTHCARE WORKERS

866-968-NUHW • nuhw.org • info@nuhw.org

October 21, 2019

Shelley Rouillard, Director
Dan Southard, Deputy Director—Office of Plan Monitoring
Jennifer E. Marsh, Attorney III—Office of Enforcement
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER FOUNDATION HEALTH PLAN INC. ENFORCEMENT MATTER NOs. 11-543 & 15-082

Dear Ms. Rouillard, Mr. Southard, Ms. Marsh and Mr. Willis:

On behalf of the National Union of Healthcare Workers ("NUHW"), I am writing to provide the Department of Managed Health Care ("DMHC") with evidence of Kaiser Permanente's noncompliance with California law and the DMHC's Cease and Desist Order issued in June of 2013.

At Kaiser's behavioral health clinic in Bakersfield, Calif., Kaiser employs two appointment-scheduling rules that appear to violate California laws and place enrollees' health and safety at risk.

The first appointment-scheduling rule is the following: At any given time, patients are prohibited from booking more than two successive individual treatment appointments with their non-physician licensed behavioral health provider (hereafter referred to as "therapist" or "therapists") regardless of patients' diagnoses or acuity levels. The second rule prohibits therapists from utilizing all of the future unscheduled appointment slots in their schedules to deliver clinically appropriate treatment to those patients whose conditions require more frequent psychotherapeutic care. Kaiser's managers have communicated these rules both verbally and in written form to the therapists practicing at the clinic.

Exhibit A is an e-mail from Robyn Field (Department Administrator, Behavioral Health Services, Kaiser's Bakersfield clinic) to therapists dated October 15, 2019. The subject line of her email is "Booking appointments" with an importance level of "High." In her e-mail, Ms. Field writes the following (emphasis is in the original).

NORTHERN CALIFORNIA
5801 Christie Ave., Suite 525
Emeryville, CA 94608

SOUTHERN CALIFORNIA
225 W. Broadway, Suite 400
Glendale, CA 91204

SACRAMENTO
1121 L Street, Suite 200
Sacramento, CA 95814

WASHINGTON, D.C.
1100 Vermont Ave. NW, Suite 1200
Washington, D.C. 20005

Greetings,

Just a reminder that even during these times of challenging access issues, the expectation per DMHC is still that we have Urgent appointments open until 48 hours prior and open intakes within 10 days. **Please refrain from converting intakes to returns and booking more than 2 appointments at a time**. Thank you for taking care of our patients!!

Robyn
Robyn Field, Ph.D.
Department Administrator

The second rule — which is referenced in Ms. Field's phrase "please refrain from converting intakes to returns" — requires additional background information. Kaiser structures most therapists' weekly schedules to include both "intake appointments" and "return appointments." "Intakes" are those individual appointments during which therapists perform diagnostic assessments for first-time patients and for patients returning after lengthy lapses in care. Following these diagnostic assessments, therapists deliver treatment to patients during so-called individual "return appointments" or "returns." Kaiser's managers typically place at least 6 to 8 "intakes" in each therapist's weekly schedule.

Many therapists' "return" slots are completely booked for months in advance due to the inadequacy of Kaiser's provider network. Consequently, when a patient requires a more rapid "return appointment" than is available in a therapist's overloaded schedule, the therapist has little to no ability to deliver such an appointment. For example, a patient with Major Depressive Disorder may exhibit suicidal ideation during an appointment with his/her therapist, requiring the therapist to schedule the patient for a subsequent individual appointment during the following week. Since all of the therapist's future "return appointments" are already booked for the next two months, the therapist attempts to use a future unscheduled "intake" slot to provide a "return appointment" to the patient.

As noted in Ms. Field's e-mail, Kaiser's managers prohibit therapists from converting future unscheduled "intakes" to "returns." This appointment-setting rule, in combination with Kaiser's inadequate provider network and its "patients-can-only-book-two-appointments-at-a-time" rule, improperly prohibit enrollees from obtaining clinically appropriate care consistent with their diagnoses and conditions.

In a September 2013 complaint to the DMHC, NUHW documented Kaiser's second appointment-setting rule and its harmful effect on Kaiser's enrollees. The complaint contained a Kaiser psychologist's e-mail message to her managers. The psychologist, who practiced at Kaiser's mental health clinic in Oakland, Calif., reported to her managers that she could not deliver clinically appropriate care to her patients given that all of her return appointments were

booked for the next five months. She writes, "I can't tell a patient with 3-6 months to live that I'll see them [for their next appointment] in 5 months." She continues:

> "These patients need access to follow-up care. I can't neglect, abandon, or marginalize these patients. They are ill and often facing mortality. They need to be able to return within weeks and then have, at a minimum, biweekly follow-up visits on a regular basis. These patients need, deserve, and frankly pay for, better service."

In her email, she reports to her managers that she has chosen to violate Kaiser's second appointment-setting rule due to her patients' needs. She writes: "Out of desperation, since I believe I am unable to provide a course of treatment that's indicated by patients' conditions, I have converted new appointment slots to return appointments." In therapists' lexicon, the term "new appointment" is synonymous with "intake appointments." Despite her effort to transparently communicate to Kaiser's managers her rationale for converting some of her future "intakes" to "returns," the psychologist was nonetheless subjected to disciplinary action by Kaiser's managers for violating the company's second appointment-setting rule. See Exhibit B for NUHW's September 2013 complaint.

In a separate complaint (filed November 2, 2018), NUHW documented Kaiser's first appointment-setting rule. The complaint provided documentary evidence detailing Kaiser's rule at its behavioral health clinic in Ventura, Calif. that prohibited enrollees from booking more than two successive individual treatment appointments with their therapist regardless of the enrollee's diagnosis or acuity. (Exhibit C)

Our concerns about Kaiser's appointment-scheduling rules include, but are not limited to, the following:

1. Kaiser's two rules unfairly limit patients' access to Kaiser's behavioral health services. By placing unnecessary appointment-scheduling hurdles in the paths of patients and providers, Kaiser improperly restricts patients' access to clinically appropriate treatment appointments. These rules' harmful effects are intensified by the limited availability of behavioral health appointments at the Bakersfield clinic. Most providers' schedules are completely booked for at least two to three months due to the inadequacy of the clinic's provider network. Thus, by preventing an enrollee from scheduling a third appointment until a future date per its "patients-can-only-book-two-appointments-at-a-time" rule, Kaiser typically forces enrollees to endure more lengthy waits for third appointments than are clinically indicated.
2. Kaiser's "patients-can-only-book-two-appointments-at-a-time" rule violates a provision of California law for which Kaiser has already been cited by the DMHC. Specifically, Rule 1300.67.2.2(c)(5)(H) states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See, for example, page 23, page

18 (Footnote 24), page 19, and page 20 of the DMHC's "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services" dated February 24, 2015.

3. Kaiser's two rules contradict the instructions it delivered to therapists in February 2015 in conjunction with the DMHC's Follow-up Survey results. On February 23, 2015, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to physician and non-physician behavioral health providers stating, in part, the following (emphasis added): "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**." (See Exhibit D)

4. Kaiser's two rules contradict its recent claims to the American Psychological Association (APA) regarding the availability of mental health treatment appointments for Kaiser's enrollees. On September 16, 2019, Kaiser's Robin Betts (VP of Quality, Clinical Effectiveness & Regulatory Services, KFHP, Northern California Region) and Patti Harvey (Senior VP of Quality, Regulatory & Clinical Operation Support, KFHP, Northern California Region) sent a six-page letter to the APA in response to an earlier letter from dozens of Kaiser's psychologists to the APA describing how Kaiser's systematic treatment delays violate professionally recognized standards of practice established by the APA. (See Exhibit E.) In their letter, Ms. Betts and Ms. Harvey state that "clinicians have complete autonomy to select and design appropriate treatment plans using evidence-based guidelines, including duration and frequency of treatment. If a clinician faces any barrier in implementing their chosen treatment plant, then they are counseled and supported by their respective clinical department managers, who will assist in removing the barrier, including creating capacity." (p. 4) Their letter continues: "Treatment planning is individualized at the clinician and patient level. Clinicians make the determination of best practices and medical necessity for modality of care, type of intervention, roles, and frequency of return follow-up." (p. 3) "If ongoing individual therapy is needed over a prolonged period for any patient, or the clinician is having difficulty implementing effective treatment for any reason, department managers assist in removing barriers and creating any needed capacity." (p. 4) Kaiser's arbitrary restrictions on scheduling appointments fly in the face of the aforementioned claims by Kaiser's top executives to the APA, a national standard-setting organization.

5. Kaiser's two rules appear to violate mental health parity laws. Kaiser reportedly places fewer appointment-scheduling restrictions on patients receiving medical and surgical care. For example, Kaiser does not force oncology patients to book only two future chemotherapy appointments at a time. Why, then, does Kaiser impose arbitrary restrictions on enrollees who seek psychotherapy appointments for depression, bipolar disorder, schizophrenia, schizoaffective disorder and other diagnoses?

6. Kaiser's two rules appear to violate California Code of Regulations § 1300.67.3, which requires HMOs to ensure that "medical decisions will not be unduly influenced by fiscal and administrative management."

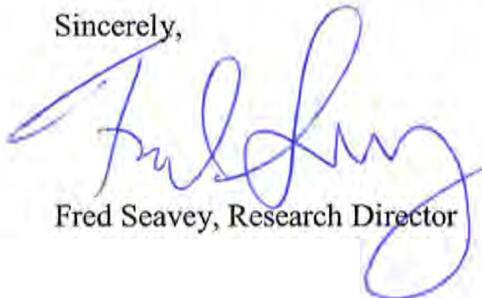
As noted above, therapists have expressed their objections to these policies to multiple Kaiser officials. Nonetheless, Kaiser has refused to correct its policies.

Furthermore, when NUHW formally brought this issue to the attention of Kaiser's regional executives more than one year ago, these officials refused to correct Kaiser's improper practices. Exhibit F contains an e-mail dated April 10, 2018 entitled "Patient care issues in Ventura" and authored by Greg Tegenkamp, the Director of NUHW's Kaiser Division. The e-mail is addressed to Paul Castaldo (Behavioral Health Care Leader, SCPMG), who served as "Regional Leader" of Behavioral Health Care for Kaiser's Southern California Region. Mr. Tegenkamp's e-mail includes three attachments. Mr. Castaldo responded verbally to Mr. Tegenkamp's e-mail, stating that clinic managers had a different view of the issue. The clinic's appointment scheduling rule remained unchanged, which prompted NUHW to submit complaint to the DMHC on November 2, 2018.

Lastly, NUHW is concerned about the DMHC's apparent failure to enforce California laws and regulations on Kaiser, our state's largest HMO. In February of 2015, the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H). Nearly five years later, Kaiser continues to violate this rule. Furthermore, Kaiser's violations at its Bakersfield clinic are taking place nearly one year after NUHW filed a detailed complaint to the DMHC regarding this same practice at Kaiser's mental health clinic in Ventura, California. We are extremely concerned that Kaiser appears determined to disregard not only California's rules and standards, but also any enforcement authority exercised by the DMHC. With nine million enrollees in California, Kaiser should not be permitted to disregard our state's laws with impunity. Furthermore, our state's regulator should be taking every reasonable step to ensure compliance by a serial violator of state laws and regulations.

NUHW requests that the DMHC (1) immediately investigate Kaiser's appointment-scheduling rules and (2) apply enhanced sanctions against Kaiser for any violations given the plan's repeated violation of California laws and regulations and its failure to correct these violations over many years. Please contact me with any questions.

Sincerely,



Fred Seavey, Research Director

EXHIBIT A

From: Robyn L. Field <Robyn.L.Field@kp.org>
Sent: Tuesday, October 15, 2019 7:38 AM
To

Subject: Booking appointments
Importance: High

Greetings,

Just a reminder that even during these times of challenging access issues, the expectation per DMHC is still that we have Urgent appointments open until 48 hours prior and open intakes within 10 days. **Please refrain from converting intakes to returns and booking more than 2 appointments at a time**. Thank you for taking care of our patients!!

Robyn

Robyn Field, Ph.D.
Department Administrator
Robyn.L.Field@kp.org

Kaiser Permanente
Behavioral Health Services
Psychiatry, Addiction Medicine, Social Medicine
4900 California Ave., Tower A, Suite 200
Bakersfield, CA 93309

(661)852-2883 (office)
8-352-2883 (tie-line)
Ruben Foster (assistant)
Ruben.A.Foster@kp.org
(661) 852-2746
kp.org/thrive

EXHIBIT B

September 16, 2013

Carol Ventura, Deputy Director – Office of Enforcement
Shelly Rouillard, Chief Deputy Director
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER PERMANENTE ENFORCEMENT MATTER NO: 11-543; ACCESS CRISIS AT OAKLAND PSYCHIATRY DEPARTMENT

Dear Ms. Ventura, Ms. Rouillard and Mr. Willis:

On behalf of NUHW, I'm writing to provide the DMHC with additional information regarding Kaiser Permanente's ongoing noncompliance with California's Timely Access regulations and other standards. As NUHW has done in the past, I'm attaching documentation regarding the wait times experienced by enrollees seeking mental health care.

A. Access Crisis at Oakland Psychiatry Department

Exhibit A contains an email message from Melinda Ginne, PhD (a licensed Psychologist who practices at Kaiser's Oakland Psychiatry Department) to Ana Sukiennik-Takaoka, Ph.D. (Manager of the department's Adult Services) and David Atkins, MD (the Sub-Chief of the department's Adult Services). The email is dated September 11, 2013.

According to her profile on Kaiser's website, Dr. Ginne is a "Behavioral Medicine Specialist" who treats "patients who have both a medical and psychological concern - for example, diabetes and depression, heart disease and anxiety, or migraine headache and stress." She is also a Geriatric Specialist and "diagnose[s] and treat[s] mental health concerns of aging such as late-life depression, anxiety, post-stroke syndrome, vascular dementia, and Alzheimer's disease." Dr. Ginne first began working at Kaiser in 1980.

Dr. Ginne's email indicates that many of her patients are currently facing severe access problems that violate California's laws and regulations, including the "clinical appropriateness standard." The following are several excerpts from Dr. Ginne's email.

> "As the only Gero-psychologist and the only Behavioral Medicine clinician still left at Kaiser Oakland, the bulk of my caseload is seriously ill medical patients and frail

elderly. Because of the lack of follow-up availability, my patients have been waiting 3 months for a routine follow-up appointment. This has been a dire situation with often adverse consequences for the patients. But now they must wait 5 months.

"Not only are they facing life-altering medical problems but they are being implicitly told that the care they need at Kaiser is unavailable.

"In the past 6-12 months my return access has become more compromised and the return dates are farther out, resulting in my first available return appointment now into the middle of January, 2014. Believe me, I can't tell a patient with 3-6 months to live that I'll see them in 5 months. I can't tell a family whose elderly mother is declining that I can't provide treatment until 2014…

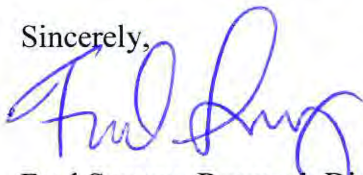
"These patients need access to follow-up care. I can't neglect, abandon, or marginalize these patients. They are ill and often facing mortality. They need to be able to return within weeks and then have, at minimum, biweekly follow-up visits on a regular basis. These patients need, deserve, and frankly pay for, better service…

"More importantly, I don't believe the department is providing clinically appropriate care for these medical patients that used to be treated by a team of Behavioral Medicine Specialists. It is unreasonable and imprudent to triage these patients to the other mental health providers in the department since they do not have training or experience in geriatrics or in treating the psychological aspects of medical illness…

"Although I brought this up over a year ago, the situation has continued to worsen. I now need to enlist your help to immediately rectify this problem. We just can't continue to fail these patients."

We request that the DMHC investigate the crisis in access described by Dr. Ginne. I would be happy to answer any questions you might have.

Sincerely,



Fred Seavey, Research Director

Attachment

ATTACHMENT A

From: Melinda Ginne/CA/KAIPERM
To: Ana V Sukiennik-Takaoka/CA/KAIPERM@Kaiperm, David A Atkins/CA/KAIPERM@Kaiperm
Cc: Clement Papazian/CA/KAIPERM@KAIPERM, Andris Skuja/CA/KAIPERM@KAIPERM
Date: 09/11/2013 03:01 PM
Subject: return access

Ana Sukiennik-Takaoka, Ph.D. Manager, Adult Service
David Atkins, MD Sub-Chief Adult Service

Dear Ana and David,

September 11, 2013

I am writing to you on behalf of the many patients I see who are sick, frail, and disabled. These patients are suffering, scared, and vulnerable. They need time and attention to process their feelings, to come to terms with their diagnosis and all of its ramifications, to make medical decisions, to adapt their lives, to make arrangements for their family, and to cope with the significant issues that their loved ones are going through.

As the only Gero-psychologist and the only Behavioral Medicine clinician still left at Kaiser Oakland, the bulk of my caseload is seriously ill medical patients and frail elderly. Because of the lack of follow-up availability, my patients have been waiting 3 months for a routine follow-up appointment. This has been a dire situation with often adverse consequences for the patients. But now they must wait 5 months.

Not only are they facing life-altering medical problems but they are being implicitly told that the care they need at Kaiser is unavailable.

In the past 6-12 months my return access has become more compromised and the return dates are farther out, resulting in my first available return appointment now into the middle of January, 2014. Believe me, I can't tell a patient with 3-6 months to live that I'll see them in 5 months. I can't tell a family whose elderly mother is declining that I can't provide treatment until 2014.

In the past, my Behavioral Medicine colleagues and I would have seen patients like this several visits and then enrolled them in a Behavioral Medicine treatment specific group. With the dismantling of the Behavioral Medicine Service the groups are gone and because of the lack of return appointments in my schedule I often can't encourage even a single follow up visit.

These patients need access to follow-up care. I can't neglect, abandon, or marginalize these patients. They are ill and often facing mortality. They need to be able to return

within weeks and then have, at minimum, biweekly follow-up visits on a regular basis. These patients need, deserve, and frankly pay for, better service.

My schedule needs to be revised immediately. Without drastic changes to my schedule I'm unable to provide a course of treatment that's indicated by these patients' high acuity conditions.

More importantly, I don't believe the department is providing clinically appropriate care for these medical patients that used to be treated by a team of Behavioral Medicine Specialists. It is unreasonable and imprudent to triage these patients to the other mental health providers in the department since they do not have training or experience in geriatrics or in treating the psychological aspects of medical illness.

Although this seems to be a broken system that needs radical revision, I have tried several strategies to manage the return demand. I have booked patients into slots that are reserved for meetings, staff education, or practice management time. I have changed phone appointment slots to appointment types I can convert into a return appointment. I often make my call backs during lunch, in fact, the only lunch break I get during the week, is on Wednesdays, otherwise I'm at my desk working.

Out of desperation, since I believe I am unable to provide a course of treatment that's indicated by patients' conditions, I have at times converted new appointment slots to return appointments. In making this decision, I gave consideration to my professional and ethical responsibilities, potential liability to Kaiser, and the risks to the patients with whom I had already entered into a therapeutic relationship. I believe, in the instances when I converted news to returns, my concerns for my existing patients outweighed concerns for patients I had not yet met. Having to chose between seeing new or return patients is not a decision any clinician should have to make. But due to inadequate staffing, the demise of behavioral medicine, and the ethical obligation I feel toward these patients, I have been forced into this position.

Although I brought this up over a year ago, the situation has continued to worsen. I now need to enlist your help to immediately rectify this problem. We just can't continue to fail these patients.

Sincerely,

Melinda

Melinda Ginne, Ph.D.
Behavioral Medicine
Gero-psychology
Kaiser-Oakland

3900 Broadway
Oakland, CA 94611
Tele: (510) 752-8302
Tie : 8-492-8302
FAX: (510) 752-6722
Hours: M, W-F

There is more to life than increasing its speed - Gandhi

EXHIBIT C

(866) 968-NUHW (6849) ❖ NUHW.org ❖ info@nuhw.org

November 2, 2018

Shelley Rouillard, Director
Dan Southard, Deputy Director—Office of Plan Monitoring
Jennifer E. Marsh, Attorney III —Office of Enforcement
James A. Willis, Senior Counsel
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814-2725

RE: KAISER FOUNDATION HEALTH PLAN INC. ENFORCEMENT MATTER NOs. 11-543 & 15-082

Dear Ms. Rouillard, Mr. Southard, Ms. Marsh and Mr. Willis:

On behalf of the National Union of Healthcare Workers ("NUHW"), I am writing to provide the Department of Managed Health Care ("DMHC") with evidence of Kaiser Permanente's noncompliance with California law and the DMHC's Cease and Desist Order issued in June of 2013.

At Kaiser's behavioral health clinic in Ventura, Calif., Kaiser employs the following appointment-scheduling rule: At any given time, patients are prohibited from booking more than two successive individual treatment appointments with their non-physician licensed behavioral health provider regardless of a patient's diagnosis or acuity. In order to place a third appointment on the schedule, the patient's treating provider typically must make an individual request for each such appointment to either Anna Garcia, Director of Behavioral Health at Kaiser Woodland Hills Medical Center or, more recently, to her subordinate. Furthermore, if permission is granted, the provider is only permitted to conduct the third appointment during non-patient care periods of the provider's schedule, such as during the provider's limited case-management slots. Patients themselves are not permitted to schedule three or more successive behavioral health appointments regardless of regardless of their diagnosis or acuity.

Our concerns about this appointment-scheduling rule include, but are not limited to, the following:

1. This policy unfairly limits patients' access to Kaiser's behavioral health services. By placing unnecessary appointment-scheduling hurdles in the paths of patients and providers, it has the effect of diminishing patients' access to treatment appointments. The harmful effects of this appointment-setting rule are intensified by the limited availability of behavioral health appointments at the Ventura clinic. Many providers' schedules are completely booked for as many as two months due to the inadequacy of the clinic's provider network. Thus, by

delaying the scheduling of a patient's third appointment until a future point in time, Kaiser forces that patient to endure a lengthier wait for the third appointment than clinically indicated.

2. This policy violates a provision of California law for which Kaiser has already been cited by the DMHC. Specifically, Rule 1300.67.2.2(c)(5)(H) states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See, for example, page 23, page 18 (Footnote 24), page 19, and page 20 of the DMHC's "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services" dated February 24, 2015.
3. This policy contradicts Kaiser's instructions to behavioral health providers issued in February 2015 in conjunction with the DMHC's Follow-up Survey results. On February 23, 2015, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to physician and non-physician behavioral health providers stating, in part, the following (emphasis added): "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**." (See Exhibit I)
4. This policy appears to violate mental health parity laws. Kaiser reportedly places fewer appointment-scheduling restrictions on patients receiving medical and surgical care. For example, Kaiser reportedly does not limit oncology patients to only receive their third chemotherapy appointment during a provider's non-patient treatment hours.
5. This policy appears to violate California Code of Regulations § 1300.67.3, which requires HMOs to ensure that "medical decisions will not be unduly influenced by fiscal and administrative management."

For nearly two years, therapists at Kaiser's Ventura clinic have expressed their objections to this policy in both verbal and written form to multiple Kaiser officials including clinic-based supervisors as well as Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Paul Costaldo (Behavioral Health Care Leader for Kaiser's Southern California Region, SCPMG). Despite these requests, Kaiser has refused to reverse its policy. Kaiser reportedly employs a similar appointment-scheduling rule at other clinic sites, including the Child & Adolescent Program at Woodland Hills.

Exhibit II is an e-mail dated February 26, 2018 entitled "Restriction of Clinical Care" and authored by Dr. Kent Coleman, a Clinical Psychologist practicing at Kaiser's Ventura Medical Office Building. The e-mail is addressed to Anna Garcia (Director of Behavioral Health at Kaiser Woodland Hills Medical Center) and Demetria Mays-Flowers (Reception Supervisor). It is copied to clinical team members and others. The following is an excerpt from the e-mail. The term "case management slots" refers to periods of time in each therapist's schedule that are intended for case management, not direct patient care.[1] In the e-mail, Dr. Coleman references his

over-booked schedule, which is common among many therapists. As of February 23, 2018, the first available open slot in Dr. Coleman's appointment schedule was more than two months later (on May 1). Today, Dr. Coleman's schedule continues to be booked out for a similar amount of time.

> Good Afternoon:
>
> I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments "on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.
>
> Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)] states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner."
>
> Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care.

Exhibit III contains an e-mail dated April 10, 2018 entitled "Patient care issues in Ventura" and authored by Greg Tegenkamp, the Director of NUHW's Kaiser Division. The e-mail is addressed to Paul Costaldo (Behavioral Health Care Leader, SCPMG), who leads Kaiser's behavioral healthcare services across Kaiser's Southern California Region. Mr. Tegenkamp's e-mail includes three attachments. Mr. Costaldo responded verbally to Mr. Tegenkamp's e-mail, stating that clinic managers had a different view of the issue. The clinic's appointment scheduling rule remains unchanged and is in force to this day. Mr. Tegenkamp's e-mail reads as follows:

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

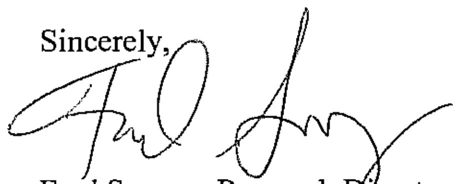
In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

NUHW requests that the DMHC investigate Kaiser's appointment-scheduling rule and its compliance with California laws and regulations. Please contact me with any questions.

Sincerely,



Fred Seavey, Research Director

---

[1] During an 8-hour workday, a therapist is scheduled to perform 6 hours of direct patient care (i.e., 75% of his/her work hours). The remaining time is designated to be used for case-management duties (1 hour) and patient management time (1 hour). During patient management time, therapists are intended to perform patient charting, make phone calls, write e-mails and letters, prepare for group classes and individual appointment, and perform other non-direct care duties associated with their clinical responsibilities.

Exhibit I

February 23, 2015

Re: DMHC Mental Health Follow-up Survey

Dear Behavioral Medicine Colleagues,

Thank you for all you do every day to care for our members in need of your compassion, caring and expertise. Your dedication to our patients, colleagues and the organization is greatly appreciated. We would like to update you on the Department of Managed Health Care (DMHC) Behavioral Health (BH) Follow-Up Survey. As you are aware, the DMHC surveyed our BH services in 2012-13. Their 2013 BH Final Report included findings regarding capacity, Health Plan oversight and inaccurate member communications. The DMHC then conducted a follow- up survey in 2013-14.

The DMHC Follow-Up Report will be released on Tuesday, February 24, and we want you to know the findings before they are made public. The DMHC has determined that two of the four original deficiencies are resolved and two are not. The DMHC reviewed 297 charts, citing 14 of the 149 charts for SCAL with untimely return access. They also have monitored our monthly access reports and while they noted significant progress, they state there is still inconsistency and lack of stability in access for some Medical Centers.

The DMHC also found three comments within the 297 charts that it identified as inaccurate. One provider inaccurately stated that longer-term therapy is not a covered benefit under the Health Plan and then offered to provide the member with suggestions for low-cost clinics in the community that the member might consider paying for separately. Another provider inaccurately stated that no one ever sees a therapist once a week in the Health Plan and that it was not a covered benefit. Although such statements were only identified in approximately 1 percent of the reviewed medical records, it is important that we provide accurate information to our members.

Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services.

While we are disappointed that the DMHC did not find that all deficiencies were fully corrected, we are also proud of the work you have done to improve and maintain access to Behavioral Health services. The new survey was based on 2013 results and we know that thanks to you, as well as our continued investments in mental health care, our access continued to improve in 2014.

Over the past five years, Southern California has increased staffing by 60 percent; has developed contracts to support therapy access; has enhanced our IOP programs, and taken other meaningful steps to improve our Behavioral Health care delivery. In concert with other Area leaders, we are planning for additional staff and offices for Behavioral Health. We know there is an additional solution to be found and have formed a Behavioral Health Strategy committee to guide that work.

We appreciate your continued commitment to our patients, which is critical in our intent to create the premier behavioral health care delivery model in the country.

Sincerely,

Edward Ellison, MD
Executive Medical Director
Southern California Permanente Medical Group

Benjamin K. Chu, MD, MPH
Regional President
Kaiser Permanente Southern California

Exhibit II

Kent L Coleman <Kent.L.Coleman@kp.org> Mon, Feb 26, 2018 at 1:06 PM
To: Demetria Mays <Demetria.M.Mays-Flowers@kp.org>
Cc: H Anna Garcia <H.Anna.Garcia@kp.org>, Fred Seavey <fseavey@nuhw.org>, "Susan K. Pembroke" <Susan.K.Pembroke@kp.org>, Lisa M Klein <Lisa.M.Klein@kp.org>, Lindsey E Mccormack <Lindsey.E.McCormack@kp.org>, "Katherine D. Cianci" <Katherine.D.Cianci@kp.org>, Cindy L Simental <Cindy.L.Simental@kp.org>, Jessica Bray <Jessica.Bray@kp.org>, Vanesa F Lay <Vanesa.F.Lay@kp.org>, Regina L Isaias <Regina.L.Isaias@kp.org>, Pamela L Chapman <Pam.X.Chapman@kp.org>, Thomas M Letvinchuck <Thomas.M.Letvinchuck@kp.org>, Ilena T Sussman <Ilena.T.Sussman@kp.org>, Sarah M Williams <Sarah.M.Williams@kp.org>, James K Borgeson <James.K.Borgeson@kp.org>, Christine L Johnson <Christine.L.Johnson@kp.org>, "Samantha W. Bookman" <Samantha.W.Bookman@kp.org>

Good Afternoon:

I am treating a patient who is dying of pancreatic cancer which has metastasized to his liver. After a difficult session last Monday, I directed this patient to see me the very next week in one of my "case management" slots. Since he already had two appointments " on the books" reception staff refused him an additional appointment. He was told and I have been told on many past occasions, I would have to ask you or Anna for permission to book additional appointment slots. This is not your call or opportunity for involvement. This is clearly a clinical decision and cannot not be influenced administratively. Additionally, since I am booked out over a month, and May 1st is my first available for any open slots, he was not going to be seen again for weeks and then bimonthly. Besides being unethical and immoral, this practice is against California laws, DMHC rules and Kaiser's own revised policies.

Title 28 California law [Rule 1300.67.2.2(c)(5)(5)(H)} states: "...periodic follow-up care, including ...periodic office visits to monitor and treat ...mental health...may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider ...." In 2015, the DMHC cited Kaiser for violating this standard. For example, DMHC wrote: "...significant delays in timeliness of follow-up appointments." In response to the DMHC report Kaiser sent a letter to all of its clinicians in Southern California stating: "Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. "**

Please investigate this problem and take the necessary steps to eliminate this administrative rule that affects and compromises our clinicians' clinical care. If for any reason you are unable to effect these changes, please advise. In my meetings with Paul Castaldo he has requested that we try to resolve these type of issues at the local level first. If unable, I will take this to region and DMHC.

I know you care about the patients. If there is anything I can do to facilitate this change let me know as well. Thanks.

Kent L. Coleman PhD

Licensed Clinical Psychologist

Steward/E Board NUHW

Ventura MOB

Exhibit III

Patient care issues in Ventura

1 message

Greg Tegenkamp <gtegenkamp@nuhw.org>
To: Paul Castaldo <Paul.C.Castaldo@kp.org>
Cc: Kent Coleman <drkdangerfield@yahoo.com>

Tue, Apr 10, 2018 at 4:13 PM

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

Thanks,

Greg Tegenkamp
NUHW Kaiser Division Director
gtegenkamp@nuhw.org

3 attachments

DMHC-Follow-UpSurveyResults_2-24-15-1.pdf
811K

KP_SoCal-LetterToClinicians2-23-15.pdf
346K

Coleman-E-mailVenturaMOB_02-26-2018.pdf
65K

EXHIBIT D

February 23, 2015

Re: DMHC Mental Health Follow-up Survey

Dear Behavioral Medicine Colleagues,

Thank you for all you do every day to care for our members in need of your compassion, caring and expertise. Your dedication to our patients, colleagues and the organization is greatly appreciated. We would like to update you on the Department of Managed Health Care (DMHC) Behavioral Health (BH) Follow-Up Survey. As you are aware, the DMHC surveyed our BH services in 2012-13. Their 2013 BH Final Report included findings regarding capacity, Health Plan oversight and inaccurate member communications. The DMHC then conducted a follow- up survey in 2013-14.

The DMHC Follow-Up Report will be released on Tuesday, February 24, and we want you to know the findings before they are made public. The DMHC has determined that two of the four original deficiencies are resolved and two are not. The DMHC reviewed 297 charts, citing 14 of the 149 charts for SCAL with untimely return access. They also have monitored our monthly access reports and while they noted significant progress, they state there is still inconsistency and lack of stability in access for some Medical Centers.

The DMHC also found three comments within the 297 charts that it identified as inaccurate. One provider inaccurately stated that longer-term therapy is not a covered benefit under the Health Plan and then offered to provide the member with suggestions for low-cost clinics in the community that the member might consider paying for separately. Another provider inaccurately stated that no one ever sees a therapist once a week in the Health Plan and that it was not a covered benefit. Although such statements were only identified in approximately 1 percent of the reviewed medical records, it is important that we provide accurate information to our members.

Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services.

While we are disappointed that the DMHC did not find that all deficiencies were fully corrected, we are also proud of the work you have done to improve and maintain access to Behavioral Health services. The new survey was based on 2013 results and we know that thanks to you, as well as our continued investments in mental health care, our access continued to improve in 2014.

Over the past five years, Southern California has increased staffing by 60 percent; has developed contracts to support therapy access; has enhanced our IOP programs, and taken other meaningful steps to improve our Behavioral Health care delivery. In concert with other Area leaders, we are planning for additional staff and offices for Behavioral Health. We know there is an additional solution to be found and have formed a Behavioral Health Strategy committee to guide that work.

We appreciate your continued commitment to our patients, which is critical in our intent to create the premier behavioral health care delivery model in the country.

Sincerely,

Edward Ellison, MD
Executive Medical Director
Southern California Permanente Medical Group

Benjamin K. Chu, MD, MPH
Regional President
Kaiser Permanente Southern California

EXHIBIT E

September 16, 2019

SENT VIA ELECTRONIC MAIL TO: ANessman@apa.org

Alan Nessman, JD – Senior Special Counsel, Legal & Regulatory Affairs
American Psychological Association
Practice Directorate
750 First St. NE
Washington, DC 20002-4242

RE: ***June 3, 2019 Letter from National Union of Healthcare Workers/APA Members***

Dear Mr. Nessman:

Thank you for your recent inquiry prompted by the June 3, 2019 letter from certain National Union of Healthcare Workers ("NUWH") and APA members ("NUHW Letter") expressing concerns regarding Kaiser Permanente members' access to timely and appropriate mental health services in California. We appreciate the opportunity to provide a response.

We agree that every Kaiser Permanente member – and in fact every American – should have access to high-quality mental health care when they need it. This is one of the top health care priorities of our day. Kaiser Permanente is at the forefront of meeting this challenge head on and we are getting results thanks to the dedication of our mental health teams. This includes our frontline clinicians in California represented by the NUHW, which we have been in contract negotiations with for more than a year.

The NUHW Letter is part of an ongoing public pressure campaign by NUHW leadership to try and pressure Kaiser Permanente management to agree to their financial demands in bargaining. We have urged NUHW's leadership to bargain constructively and stop putting our patients in the middle of their contract demands. The NUHW Letter is a clear attempt to drag the APA into the NUHW's corporate campaign. Despite the NUHW's tactics, Kaiser Permanente remains committed to responsibly reaching a new contract agreement, which is what our therapists and patients deserve.

Below we provide an overview of Kaiser Permanente's commitment to ensuring access to timely and appropriate mental health services in our two California regions. We also respond to the unfounded allegations raised in the NUHW Letter.

Kaiser Permanente California – Mental Health Services

Kaiser Permanente Northern California is the only health plan in the state to earn 5 stars – the highest possible rating – for behavioral and mental health care access and quality according to the California Office of the Patient Advocate (OPA) 2018 Report Card. Kaiser Permanente Southern California is one of only three plans in the state to receive the Report Card's next highest possible rating.

Still, we know that all mental health care providers — including Kaiser Permanente — have work to do to improve. We have a broad range of initiatives designed to increase access, continually improve and set a new standard of service excellence. They include:

- **Improved Quality Oversight.** Kaiser Permanente is committed to timely access, and we continue to improve our performance in meeting or exceeding the established regulatory standard for first appointments for behavioral health. We actively monitor and review the quality and service levels for behavioral health services, providing feedback on gaps in performance and the need to perform to plan. This includes auditing of triage assessment documentation for initial behavioral health appointments booked beyond regulatory guidelines. We continue auditing individual provider treatment plans to ensure follow-up appointments are offered at return intervals consistent with the patient's treatment plan. When a site is out of compliance, we ensure that corrective action plans ("CAPs") document the root cause analysis and corrective action interventions. And, we continue to refine the escalation process, enhance interventions, and employ best practices to make progress with sites that are out of compliance.

- **Adding More Resources:** In its February 2019 report on the overall shortage of health professionals in California, the California Future Health Workforce Commission states that unless the state makes dramatic policy changes, "California will have 41% fewer psychiatrists and 11% fewer psychologists, marriage and family therapists, clinical counselors, and social workers than it will need." Despite the national and state shortage of trained mental health professionals, Kaiser Permanente has hired more than 1,100 new therapists and filled more than 2,600 mental health positions in California from 2016 through present, and we continue to hire more (also see "Growing the Workforce" below). Through our integrated delivery model, our members are offered and receive comprehensive mental health services in settings where they are and where they want to receive care.

- **More Treatment Locations:** We are accelerating our ongoing $700-million project to expand and enhance our mental health care treatment facilities, with the goal of making mental health care more available and improving access in environments that offer our patients convenience, comfort and privacy.

- **Embedding Mental Health Care in Primary Care:** Our primary care and mental health providers work together to make mental health and wellness part of a patient's total health. We are making it possible for members to receive mental health care throughout our organization, including embedding mental health professionals in primary care clinics and emergency departments.

- **Innovative Options:** Our use of innovative technology is growing rapidly, driven by the preferences of our patients for ease of access and convenience. On an annual basis, we provide hundreds of thousands of tele-health visits statewide, allowing patients to communicate with their therapists from the privacy and comfort of their homes.

- **Growing the Workforce:** We provide an extensive array of training opportunities statewide for more than 300 trainees each year, including residency training programs in psychiatry in Northern and Southern California, and training opportunities and assistantships for post-masters and pre- and post-doctoral level mental health providers. We are moving forward with several initiatives totaling $50 million that will increase the number of people who are entering mental health professions. This includes tuition assistance for our current employees, fellowships and residencies for future hires, and grants to expand capacity in degree programs, with an emphasis in graduating bilingual and/or diverse students who reflect community needs. We are also committing $6 million to encourage our therapists' engagement in clinical research to further develop evidence-based treatment and outcomes.

- **Designing the Future of Care:** We've proposed creating an intensive work group of therapists and management, to advance innovation and evidence-based practice in our model of care. We believe – as do our therapists – that the dramatic increase in mental health care demand cannot be fully met without changes in the way mental health services are provided. We are reimagining the continuum of mental health and addiction care to incorporate opportunities afforded by new technologies, the use of collaborative care in primary care, and by rigorously applying the evidence base of what works in specialty care. This new continuum will allow us to serve the mental health needs of our population in new and even more effective ways.

- **Reducing Stigma:** Kaiser Permanente is committed to reducing stigma associated with mental health treatment. For example, in 2016, Kaiser Permanente launched the national "Find Your Words" public health awareness campaign (findyourwords.org), joining forces with others in the field to spark a national conversation about depression. This is one of several national initiatives we have launched to help reduce the stigma that can be a personal barrier to reaching out for mental health support.

<u>Allegations in NUHW Letter</u>

The NUHW Letter alleges Kaiser Permanente has violated professionally recognized standards of practice in delivery mental health services. Each allegation is separately addressed below.

1. **Kaiser Permanente's Northern California and Southern California Behavioral Health Clinics are meeting timely access requirements in compliance with professionally recognized standards of practice.**

We are proud of the care that our providers give to our members. Treatment planning is individualized at the clinician and patient level. Clinicians make the determination of best practices and medical necessity for modality of care, type of intervention, goals, and frequency of return follow-up. These aspects of treatment planning and member-patient satisfaction are monitored through routinely measured Feedback Informed Care as well and the robust statewide quality oversight structure addressed above.

Kaiser Permanente has an existing well-understood practice and expectation that if any provider believes any member requires more frequent appointments than they feel able to provide, or care that cannot be accommodated within our system, the providers are expected to escalate the case to their department leadership in order to discuss options. These options often include adjusting individual provider schedules to create more availability, reducing the number of new patients assigned to a particular provider in order to increase follow up availability, considering referral to an external contract provider, or some other appropriate change in treatment planning.

Our department managers and clinical supervisors are always available to advise on scheduling and other resources to support providers' treatment plans. Clinicians' schedules are designed in such a manner that for each new patient evaluated, a weekly return visit can be accessed per the clinician's judgment. In addition, weekly group modalities and medication modalities are available to augment individual therapy, if needed. Such design ensures evidence based best practices can be implemented efficiently. Clinicians have been trained in and are encouraged to use outcome measures and Feedback Informed Care to assist in assessing patient needs for ongoing treatment. If ongoing individual therapy is needed over a prolonged period for any patient, or the clinician is having difficulty implementing effective treatment for any reason, department managers assist in removing barriers and creating any needed capacity.

To further improve the treatment of our members, our Psychiatry and Addiction Medicine departments have developed and implemented innovative programs based on evidence based best practices. Some examples of these evidence based programs include (1) enhanced processes for patients and providers to review treatment plans and progress at each visit; (2) the use of Feedback Informed Care, an evidence based support tool that providers use to improve the effectiveness of care and speed of recovery procedures; and (3) a customized program that connects patients with the appropriate level of care consistent with access standards. Our internal monitoring shows these programs provide significant benefit to our members in addressing their mental health and addiction care needs.

2. Kaiser Permanente Embraces Clinician Autonomy.

Mental Health clinicians have complete autonomy to select and design appropriate treatment plans using evidence-based guidelines, including duration and frequency of treatment. If a clinician faces any barrier in implementing their chosen treatment plan, then they are counseled and supported by their respective clinical department managers, who will assist in removing the barrier, including creating capacity. Additionally, attendance at professional case conferences and regular individual meetings with direct managers for all clinicians ensures regular review of active cases and provides the requisite support needed for the delivery of evidence-based treatment models within the paradigm of Feedback Informed Care.

3. Kaiser Permanente is a Leader in Telehealth.

The NUHW Letter refers to and attaches a "58-page complaint" NUHW filed with Kaiser's California regulator, the Department of Managed Health Care ("DMHC") concerning telehealth services. NUHW's

complaint is wrong and misleading. It is a disservice to Kaiser Permanente's therapists who are providing high quality care and to all that are seeking to improve access and care for our members. NUHW's actions threaten to undermine member confidence in an innovative way to deliver accelerated assessment and treatment through a welcoming and easily accessible process.

For years, Kaiser Permanente has been on the leading edge of delivering telemedicine to our members, so that they have quicker and more convenient access to the care they need. This approach is consistent with what our members want and what innovative healthcare organizations are doing across the country. Currently, more than half of U.S. hospitals connect with members and consulting practitioners through virtual visits and other technology.

Despite the inflammatory and misleading nature of NUHW's complaint, Kaiser Permanente investigated NUHW's allegations and provided a confidential response the DMHC in June of this year. We meet regularly with the DMHC to discuss oversight of mental health services in California, including NUHW's allegations. Kaiser Permanente remains committed to providing the best possible care to its members and will continue to work to improve and innovate care in a manner that best serves its members.

4. Kaiser Permanente is Committed to Continuously Improving.

Kaiser Permanente is proud of the behavioral health services that it offers and provides its members in California. We also take pride in being a learning organization that seeks different ways to continuously improve our operations and services. The NUHW Letter repeats and recites several of its past complaints, including various findings and actions taken by the DMHC dating back to 2013. Since NUHW's initiation of its first corporate campaign in 2011, Kaiser Permanente has responded to numerous allegations. While many of NUHW's allegations have been meritless, misleading and false, over the past eight years Kaiser Permanente has recognized those points that presented opportunities to improve. Kaiser Permanente continues to critically review its operations and performance and is committed to serving our members and setting a new standard of service.

5. NUHW Self-Administered Survey.

NUHW has not provided Kaiser Permanente with any information that would allow us to understand the validity of the NUHW self-administered survey in terms of design or administration. Kaiser Permanente is unable to assess this survey in terms of question construction, how it was administered, messaging that may have accompanied its administration or how any results were interpreted. In addition, the survey was completed while in the midst of protracted contract negotiations that are yet to be resolved.

* * *

Kaiser Permanente appreciates the opportunity to engage with the American Psychological Association. We remain available to address any questions or concerns your organization may have.

Sincerely,

/s/ Patty A. Harvey
Patti A. Harvey, RN, MPH, CPHQ
Senior Vice President, Quality, Regulatory & Clinical Operation Support
Kaiser Foundation Health Plan, Inc. and Hospitals
Southern California Region

/s/ Robin Betts
Robin Betts, MBA-HM, RN, CPHQ
Vice President, Quality, Clinical Effectiveness & Regulatory Services
Kaiser Foundation Health Plan, Inc. and Hospitals
Northern California Region

cc: Gracelyn McDermott
Executive Director, Account Management
Kaiser Permanente Mid-Atlantic States

Mark R. Ruszczyk
Vice President, Marketing, Sales & Business Development
Kaiser Permanente Mid-Atlantic States

EXHIBIT F

Patient care issues in Ventura

1 message

Greg Tegenkamp <gtegenkamp@nuhw.org>
To: Paul Castaldo <Paul.C.Castaldo@kp.org>
Cc: Kent Coleman <drkdangerfield@yahoo.com>

Tue, Apr 10, 2018 at 4:13 PM

Paul,

I want to ask for your help in addressing a DMHC/patient-care issue at one of our clinics. Thus far, a clinician has tried to resolve the issue at a local level without success.

Here's the problem: The Ventura MOB apparently has a policy that prohibits its patients and staff from scheduling more than two behavioral health appointments at a time for a given patient. Recently, Dr. Coleman (a Clinical Psychologist) and one of his patients ran headlong into this policy when Dr. Coleman asked the patient, who is dying of metastatic pancreatic cancer, to schedule an appointment one week later in one of his case management slots. When the patient attempted to schedule the appointment, the reception staff refused to do so because the patient already had two appointments on the books.

Our concerns include the following: (1) this is bad patient care, (2) this policy appears to violate a provision of California law for which Kaiser has already been cited by the DMHC, and (3) this policy appears to violate regional leaders' own statements about appointment-scheduling standards.

As far as DMHC policy, in February 2015 the DMHC cited Kaiser for violating Rule 1300.67.2.2(c)(5)(H)], which states that "periodic follow-up care, including... periodic office visits to monitor and treat... mental health conditions... may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice." See for example pages 23, 18 (Footnote 24), 19, and 20 of the attached DMHC report (DMHC, "Routine Survey Follow-Up Report of Kaiser Foundation Health Plan, Inc. Behavioral Health Services," February 24, 2015).

As far as Kaiser's appointment-scheduling standards, Dr. Ed Ellison and Dr. Ben Chu sent a joint letter to all NUHW clinicians on February 23, 2015 stating the following. A copy is attached.

"Just to be sure there is no risk of miscommunication to patients, we would like to reiterate that **the Plan covers behavioral health services for the length of time and with the frequency deemed medically necessary by the practitioner**. As you know, we have a multi-modal approach to treatment. If you determine that a member's treatment plan cannot be accommodated within our system, it is important to escalate those issues to your manager, so that we can make sure that members are receiving the coverage to which they are entitled. If members have any questions about their coverage, please direct them to Member Services." (Emphasis added)

In addition, we have concerns about compliance with parity laws. It's unclear why appointment-setting practices should be more restrictive in behavioral health than in other departments.

As I mentioned, Dr. Coleman has attempted to resolve this issue at the local level without success. After raising his concerns about this and concomitant issues in verbal conversations for over a year, he sent the attached e-mail on February 26, 2018. Since then, he has received no written response. Ana Garcia suggested to Dr. Coleman that the clinic would make an exception to its only-two-booked-appointments rule if Dr. Coleman want to book a third appointment for a given patient into his Case Management time. This offers no solution to what appears to be an overly restrictive and improper appointment-scheduling policy. Furthermore, Anna Garcia's suggested workaround would simply penalize clinicians who are trying to treat patients with acute diagnoses that require more frequent treatment.

Can you help us address this issue? What are your thoughts on next steps?

Thanks,

Greg Tegenkamp
NUHW Kaiser Division Director
gtegenkamp@nuhw.org

3 attachments

DMHC-Follow-UpSurveyResults_2-24-15-1.pdf
811K

KP_SoCal-LetterToClinicians2-23-15.pdf
346K

Coleman-E-mailVenturaMOB_02-26-2018.pdf
65K